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SAN FRANCISCO MENTAL HEALTH BOARD

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MEETING OF THE MENTAL HEALTH BOARD

Wednesday, January 9, 2002
1380 Howard, Room 537
6:30 p.m.

AGENDA

Public comments will be taken for each agenda item.

1.0 CALL TO ORDER AND CONSENT CALENDAR (10 minutes)
For discussion and proposed action

1.1 Call to Order and Announcements from the Chair

1.2 Consent Calendar (Attachment A)

1.2.a PROPOSED ACTION: Resolution that the Board approve the minutes of the MHB meeting on November 14, 2001.

1.2.b PROPOSED RESOLUTION: Be it resolved that the minutes of the Mental Health Board meeting of December 1, 2001, be approved as submitted.

1.2.c PROPOSED ACTION: Resolution approving leaves of absence for the MHB meeting on January 9, 2002:

2.0 PRESENTATION: JO RUFFIN, Director of Community Mental Health Services AFTERMATH OF SEPTEMBER 11TH EVENTS AND FUTURE BUDGET ISSUES (50 minutes)

Jo Ruffin will present information about service needs following September 11th and the impact on future budgets.

3.0 DIRECTORS REPORTS (30 minutes)
For discussion

3.1 Report from the Director of Community Mental Health Services
A report on the activities and operations of Community Mental Health Services, including budget, planning, policy, and programs and services.

3.2 Report from the Executive Director of the Mental Health Board
A report including updates and announcements regarding the activities and operations of the Board.

4.0 MENTAL HEALTH BOARD COMMITTEES (20 minutes)
For discussion and proposed action

4.1 Report of the Chair of the Board and Executive Committee
The chair will report discussions and actions of Executive Committee.

4.1.a PROPOSED ACTION: Resolution adopting the priorities for the Menatl Health Baord for 2002. (Attachment B)

4.1.b PROPOSED ACTION: Resolution that the Mental Health Board commend Nancy Presson for her years of service to Community Mental Health Services. (Attachment C)

4.2 Children's Committee
No report

4.3 Cultural Competency & Special Populations Committee
No report

4.4 Program and Services Committee
No report

4.4.a PROPOSED ACTION: Resolution that the Mental Health Board urges the Mayor and the Board of Supervisors to oppose AB 1421, Mental Health, Involuntary Outpatient Treatment. (Attachment D)

4.5 State Liaison
A report on developments regarding mental health services, policy, and funding at the state level, including the California legislature, the State Department of Mental Health, and other statewide advocacy or policy organizations.

5.0 PUBLIC COMMENT (10 minutes)
This is an opportunity for members of the public to address the Mental Health Board on items of interest to the public that are within the subject matter jurisdiction of the Mental Health Board. Additionally, public comments will be taken for each agenda item.

This agenda and all attachments can be viewed at: www.ci.sf.ca.us/mental_health. Attachments are also available at the Mental Health Board Office, 1380 Howard Street, Suite 510, telephone 255-3474.

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MENTAL HEALTH BOARD
ATTACHMENT A
January 9, 2002

CONSENT CALENDAR

All items on the Consent Calendar are handled through a single vote. There will be no discussion unless a member requests it, in which case the item will be removed from Consent Calendar and discussed. Additional names may be added to the leave of absence resolution during the meeting.

1.2.a **PROPOSED RESOLUTION: Be it resolved that the minutes of the Mental Health Board meeting of November 14, 2001, be approved as submitted.**

1.2.b **PROPOSED RESOLUTION: Be it resolved that the minutes of the Mental Health Board meeting of December 1, 2001, be approved as submitted.**

1.2.c **PROPOSED RESOLUTION: Be it resolved that the Mental Health Board grants leaves of absence for the meeting of January 9, 2002, to the following members: Peggy Gilleran**

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MENTAL HEALTH BOARD
ATTACHMENT B
January 9, 2002

PROPOSED RESOLUTION (MHB-2002-xx) Regarding priorities of the Mental Health Board for 2002.

Be it resolved that the Mental Health Board adopts the following as its priority areas of focus for 2002:

1) **The consequences and aftermath of September 11th.**

   Including: Trauma and other mental health issues, demand for services, access to the system, quality of services, the Wellness and Recovery Model, immigration, and transition services.

2) **Advocacy**

   Including: Meeting with supervisors, writing letters, networking, partnering with Community Mental Health Services, the Americans with Disabilities Act, and responding to legislative issues.

3) **The City budget for mental health services.**

   Including: Monitoring the development of the budget, anticipating cuts and planning strategies for responding, working closely with CMHS, helping consumers deal with the changes.

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MENTAL HEALTH BOARD
ATTACHMENT C
January 9, 2002

PROPOSED RESOLUTION (MHB-2002-xx) Honoring Nancy Presson upon her retirement from Community Mental Health Services:

Be it resolved that the San Francisco Mental Health Baord present the following award to Nancy Presson:

The Mental Health Board of San Francisco gratefully honors

Nancy Presson

For your total and absolute commitment to the best possible mental health services.
For being action-oriented and doing whatever it takes
to accomplish seemingly impossible goals.
For your reassuring calm in the midst of multiple, simultaneous crises.
For treating everyone with personal respect.
For being able to transcend and transform rigid regulations and rules
in order to get clients the treatment they need.
For your ability to grasp incredibly complex issues and explain them to us in
understandable ways.
For your leadership in the funding and building of
the Mental Health Rehabilitation Facility.
For doing the ground work on the Children's System of Care.
For your warmth, creativity, graciousness, sense of humor,
and the maturity of your leadership.

We admire and applaud the choice you have made to become
an elementary school teacher,
but we will miss you dearly.

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MENTAL HEALTH BOARD
ATTACHMENT D
January 9, 2002

PROPOSED RESOLUTION (MHB 2002-xx) REGARDING AB 1421, MENTAL HEALTH: INVOLUNTARY TREATMENT

WHEREAS, many people with severe psychiatric disabilities are unable or unwilling to access or receive mental health services, with disastrous results for the individual, their family and the community; and

WHEREAS, the Lanterman-Petris-Short Act, a California law enacted in 1967, already provides for involuntary in-patient treatment for those people whose mental disabilities make them "gravely disabled" or " a danger to self or others;" and

WHEREAS, the hearing, "Mandatory Mental Health Treatment: For Good or For Ill?" was held October 12, 2001 and public testimony was overwhelming against Involuntary Treatment and AB 1421; and

WHEREAS, in 1999 and 2000, over 300 homeless people in San Francisco were surveyed by the Coalition on Homelessness and over 92% said that if mental health programs were available that met their needs, they would willingly utilize services; and about one third said that they had attempted to access services and were unsuccessful; and

WHEREAS, the Little Hoover Commission report "Being There: Making a Commitment to Mental Health," Executive Summary, November, 2000 found:

"California's involuntary commitment law—the LPS Act—is one of the most controversial mental health issues of the day; however, the Commission found the most important and immediate concern to be the 1.5 million Californians who need help but do not receive it;" and

WHEREAS, as we have not been able to afford mental health care for many of our citizens who ask for it, we should not go looking for people at some added expense on which to force care that they do not want; and

WHEREAS, the Duke Study, in North Carolina, found that in order to effectively treat people with severe psychiatric disabilities a minimum of 36 treatment contacts a year were necessary; and whereas in California, people with severe psychiatric disabilities receive an average of three treatment encounters a year; and

WHEREAS, the MacArthur Treatment Competence Study found, "Most patients hospitalized with serious mental illness have abilities similar to persons without mental illness for making treatment decisions. Taken by itself, mental illness does not invariably impair decision making capacities;" and

WHEREAS, the MacArthur Violence Risk Assessment Study found that "the prevalence of violence among people who have been discharged from a hospital and who do not have symptoms of substance abuse is about the same as the prevalence among other people living in their communities who do not have symptoms of substance abuse;" and

WHEREAS, the Well Being Project, a research project supported by the California Department of Mental Health, found that 55% of clients interviewed who had experienced forced treatment reported that fear of forces treatment caused them to avoid all treatment for psychological and emotional problems; and

WHEREAS, people with psychiatric disabilities testified that involuntary mental health treatment undermines the development of a trusting, therapeutic relationship between the client, the mental health practitioner and their family; and

WHEREAS, people with psychiatric disabilities also testified that psychotropic medications, while they can be helpful in controlling symptoms, can also have very serious side effects; and should only be administered after informed consent; and

WHEREAS, the RAND study, "The Effectiveness of Involuntary Outpatient Treatment: Empirical Evidence and the Experience of Eight States," found that "these findings cannot be generalized to suggest that involuntary outpatient treatment would be more effective than alternative, non-coercive interventions for all target populations;" and

WHEREAS, AB 1421, a bill that would provide funding for Assisted Outpatient Treatment (involuntary treatment) is intended to serve a small number of people with severe psychiatric disabilities but defines the eligibility criteria for this treatment so broadly that many people with psychiatric disabilities could be inappropriately involuntarily treated; and

WHEREAS, the laws governing the commitment procedure in AB 1421 is so vague as to allow that the petition may be heard without its subject being present if "appropriate attempts to elicit the attendance of the person have failed;" and

WHEREAS, of the stakeholders the RAND study interviewed who supported involuntary outpatient treatment, there was significant "skepticism and uncertainty about the practical application of these laws;" and whereas the RAND study found that involuntary outpatient treatment is used infrequently in states where there are laws permitting it; and

WHEREAS, the RAND Institute study on the "Effectiveness of Involuntary Outpatient Treatment" found "clear evidence that alternative, community-based mental health treatments can produce good outcomes for people with severe mental illness;" and

WHEREAS, the landmark report "Mental Health: A Report of the Surgeon General," January, 2000, states, "One point is clear: the need for coercion should be reduced significantly when adequate services are readily accessible to individuals with severe mental disorders who pose a treat of danger to themselves or others;"and

WHEREAS, Involuntary Outpatient Treatment will subject many to the judicial system and will make those who steadfastly refuse to accept ordered treatment in contempt of court, thus establishing a new class of criminal; and whereas refusal of mental health treatment should not be treated as a crime any more that refusal of other health treatment; and

WHEREAS, the voluntary, comprehensive community-based programs resulting from State bills AB 34, AB 334, and AB 2034 provide the necessary outpatient treatment for individuals previously difficult to engage such as those who are homeless and exiting the jail system; and

WHEREAS. programs created in response to AB 2034 have been very effective in reducing hospital stays and jail time by providing intensive voluntary outpatient case management and support for individuals; and

WHEREAS. AB 1424, which became effective January 1, 2002, allows the medical history of a person to be considered in determining whether someone is gravely disabled or a danger to themselves or others, and whereas inclusion of this information at the certification hearings is expected to significantly impact decisions regarding involuntary inpatient commitment; and

WHEREAS, the National Council on Disability, an independent federal agency mandated to make recommendations to the President and Congress, extensively interviewed people with psychiatric disabilities and has recommended that:

"Laws that allow the use of involuntary treatments such as forced drugging and inpatient and outpatient commitment should be viewed as inherently suspect, because they are incompatible with the principle of self-determination. Public policy needs to move in the direction of a totally voluntary community-based mental health system that safeguards human dignity and respects individual autonomy" (Core Recommendation #1); and

WHEREAS, much of this resolution has been adopted from a resolution passed by the Mayor's Disability Council in San Francisco in November 2000; now, therefore

BE IT RESOLVED THAT, the San Francisco Mental Health Board urges the Mayor and the Board of Supervisors to support increased mental health funding for voluntary, community-based services and that the Mental Health Board specifically urges that the City and County of San Francisco take a position of opposition with regard to AB 1421 (Thomson); and

BE IT FURTHER RESOLVED THAT, the San Francisco Mental Health Board urges Community Mental Health Services in San Francisco, as well as the State of California, to develop ways of responding to the concerns of family members, such as by increasing mobile crisis services, by having support groups for family members as needed, and by case managers being open to hearing from family members as appropriate, and

BE IT FURTHER RESOLVED THAT, the San Francisco Mental Health Board urges the Mayor and the Board of Supervisors to provide funding for mobile crisis services in San Francisco 24 hours a day, seven days a week.

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UNADOPTED MINUTES

Mental Health Board
Saturday, January 9, 2002
1380 Howard Street, Room 537
San Francisco, CA 94103
6:30 p.m.

BOARD MEMBERS PRESENT: Jim Beauford, Ph.D. (Chair); Tim Agar; Bridgett Brown; April Martin Chartrand; Bob Douglas; Pat Harrison; Alex Kitzes, Ph.D.; Carol Knight; Andrea Leung, L.C.S.W., A.C.S.W.; Rose Chung for Supervisor Aaron Peskin; Mickey Shipley; Ted Stinson; Lora Traveler; Chet Villalba; Kate Walker; Dennis Yun.

BOARD MEMBERS ON LEAVE: Peggy Gilleran; Chet Villalba.

BOARD MEMBERS ABSENT: none.

OTHERS PRESENT: Jo Ruffin (CMHS Director); Tiffeny Jimenez; Melvin Escobar; Milly Mayfield (*SF Independent*); John Dorsey (Community Vocational Enterprises); Rick Nizzardini (Glide); Emeric Kalman; Helynna Brooke (MHB Executive Director); Rich Snowdon (MHB Administrator).

1.0 CALL TO ORDER AND CONSENT CALENDAR

The meeting was called to order at 7:45 p.m by Jim Beauford, Chair: This will be the last meeting for seven of our Board members. I have full faith that the Board is going to do well this coming year in terms of advocacy for the clients of the mental health system. Those of us who will be leaving will still be available to the ongoing members if you want consultation. We've become friends and family.

Consent Calendar

RESOLUTION (MHB-2002-01): Be it resolved that the minutes of the Mental Health Board meeting of November 14, 2001, be approved as submitted. (Passed unanimously.)

RESOLUTION (MHB-2002-02): Be it resolved that the minutes of the Mental Health Board meeting of December 1, 2001, be approved as submitted. (Passed unanimously.)

RESOLUTION (MHB-2002-03): Be it resolved that the Mental Health Board grants leaves of absence for the meeting of January 9, 2002, to the following members: Peggy Gilleran. (Passed unanimously.)

2.0 PRESENTATION BY JO RUFFIN ON THE AFTERMATH OF SEPTEMBER 11th AND FUTURE BUDGET ISSUES

Ms. Ruffin: Tonight, I wanted to recap our activities after September 11th. One of the duties the state assigns to county mental health is to respond in the aftermath of disasters. We provide critical incident stress debriefing. This is basically designed to help relieve symptoms of critical incidents in the short term. We help deal with issues of trauma any of the people of San Francisco are experiencing.

All of our county employees are designated disaster specialists. Each county site has a disaster plan. And the Department of Public Health as a whole has disaster plan to respond to any situations that occur. Also we have a memorandum of understanding with the Red Cross, and we coordinate with them in providing services. They rely very heavily on us to provide the mental health services in response to a disaster.

Our disaster plan gets activated even when there's a small disaster, such as the fires that have been happening at hotels on the weekends. We make an assessment of the people involved to see what they need and offer counseling.

When the September 11th disaster occurred we had a unique experience as a society. We experienced that disaster happening to us personally even if we weren't directly involved. This has a lot to do with what's called disaster exposure: how close you are to it and how long it lasts. The September 11th disaster had very intense media coverage, so we all experienced disaster exposure.

The intensity my be varied depending on what images you saw on TV. These images may still be with you today and may be hard to get out of your mind. Because of the recording of phone calls on Flight 93, the media took us right inside that airplane. We heard the actual conversations that went on between people on the flight and loved ones they were able to contact. You might have found yourself very intensely affected by that tragedy.

When September 11th happened, the Civic Center was shut down. There were a number of our programs in the area that were ordered to close down, and it was important that the staff and clients knew what to do at that point. It was a difficult time. We weren't sure if any other attacks were going to happen.

We had a child-focused program in the area near the Transamerica Pyramid, and it was given an order to be evacuated. The parents of the children weren't available, so the staff had to take the children somewhere. They ended up in the park. And then we learned some of the problems with the disaster plan. The children needed an inside place. Another community program made space and allowed the kids to come in.

Almost immediately, we started getting calls from the schools, asking us to come talk with staff, teachers, and students. A lot of our children's services staff went out to the schools.

We got an emergency call from the Marriott Hotel. They had a lot of conventioneers from New York who weren't able to get through to their families and were quite upset.

The Mobile Crisis Team went out and did debriefing with them.

We had calls from the schools through the month of October.

We're getting anecdotal reports of an increase in people seeking counseling in the private sector. The disaster has activated prior trauma experiences for many people and they are seeking help.

I would say almost everything we did in the mental health system incorporated concerns about our clients' reactions to the disaster. We focused on helping people talk about their feelings and not let them go underground. On the whole, our clients did very well.

We tried to do a lot of media coverage about dealing with trauma responses. We put materials out on the website and distributed materials on how children respond to disasters with a lot of practical tips for parents.

April Chartrand was instrumental in getting me included as a speaker at a forum on terrorism. I had a chance to talk about the cycle of trauma.

We also did a number of activities with the Arab American Center though our cultural competency section. We invited people from the Center to go into the schools with us. A lot of the middle eastern children were being harassed or were afraid of being harassed. We are also co-sponsoring a training this month on mental health issues in Arab American communities.

People are reporting to me now that things have calmed down. We're not seeing surges in the need for services now. That finding fits the disaster cycle. We've been through enough time now that there is beginning to be resolution of people's feelings. But if there were to be another terrorist act, that would set off the September 11th trauma again.

DPH is looking at funds for disaster situations. There is a possibility that we might get a heliport for SFGH, since that is a well know trauma center.

Ms. Harrison: Has there been any dialogue with the churches about where they fit in? A lot of the churches responded with actions of their own, and it seems they ought to be a permanent part of the plan.

Ms. Ruffin: That's a good point. I'll check into it. There's a citywide plan, but I don't know how the churches fit into that.

We feel strongly that our contractor agencies should be part of our disaster plan and they are very responsive to this. We often start by calling on our City staff, because we don't have a way to pay contract staff. But some of them volunteer.

We did do some debriefing with some of the teams sent to Ground Zero in New York from Menlo Park and Alameda County.

Ms. Traveler: This was certainly a comprehensive report and the Department is to be commended for an in-depth, comprehensive response.

Ms. Ruffin: This is something we've grown into over the years. When the Loma Prieta earthquake happened we didn't have a structure in place. We did a lot then, but learned a lot, too, and that has paid off in this disaster.

Ms. Brooke: In terms of the budget and the events on September 11th, we were already facing budget problems, before the attacks. I know many of the public services are funded by the General Fund which depends on tourists. In terms of the impact on the budget, how is mental health faring?

Ms. Ruffin: The Department of Public Health is projecting a $56 million shortfall. This is out of almost a billion dollar budget for the Health Department as a whole. What that means is that we have to cover our own cost of living raises which we've already negotiated with the unions. So we had to find $26 million to cover the civil service pay increase. In addition, all City departments are being asked by the Mayor to project an additional ten percent cut due to the loss of revenues as a consequence of the decrease in tourists and loss of high-tech income.

We need to come up with $4 million in cost savings, plus an additional $700,000 for our section of DPH. We have had some losses of revenues in some programs, plus an increase in Napa State Hospital costs. We have been able to cover this with additional revenues.

Unfortunately the contractors are not getting a COLA unless they can cover it themselves.

So it's been a big job to figure out how to respond, but if we are able to at least get the revenue to cover that $56 million, then our baseline budget will be in pretty good shape.

But the problem is that we have the additional 10% cut that we are being asked to make. That is an additional $8 million in cuts, and that is devastating. That's what we're working on now.

What we're trying to do in the system of care is to provide as many services as possible in our community-based programs so clients don't have to go to the hospital or Napa.

Our plan so far in working on this $8 million cut is as follows: We decided to keep consumer-run services and self-help programs untouched. We tried everything we could to maintain housing and supported housing.

We've made intensive case management services a priority, but then there is not a lot left. That means there will be cuts in all other areas except the ones I just named.

We can't take more out of Napa. We will make a reduction in long-term care in terms of out-of-county facilities. We're cutting inpatient services in private hospitals. Psychiatric Emergency Services is in the SFGH budget, and there is no change there.

We're trying to maintain acute diversion. There will be substantial cuts to transitional residential treatment. We want to try to maintain those facilities at least as housing, and not to lose those sites.

We'll keep the vocational rehabilitation sites.

Our plan is still a work in progress. So it won't be official until I can get a package to you. It looks like we'll have to eliminate all our day treatment programs. And we'll end up having to cut a bunch of outpatient programming.

The other problem we have is that all of our services produce a tremendous amount of revenue, and in losing that revenue, we'll lose an additional $4 million. So when you add that in, this is essentially a $12 million cut out of our system. I'm only talking about mental health. This same kind of cutting is going on in substance abuse and at SFGH.

We're trying to figure out a way to help the Supervisors understand the ramifications of the hard decisions they are going to have to make.

When the final budget document comes out, it may change, and we can only hope it will. If the City has a windfall in revenues, then our cuts won't be as bad. But there aren't a lot of good signs about revenue going up.

We're going to try to maintain contact with the clients, if that means doing more groups. The cuts will impair our ability to move people out of the acute programs and into the community.

If we don't have the private hospital money, then clients will be lined up at SFGH. If there is no money for transitional housing, then people will be stuck at General or they'll be out on the streets. Then you'll see the fallout on other systems like the jail system.

This is not something the Mayor created. This is the result of less hotel revenues, and there may be some hard choices ahead. But we don't want to destroy something that we won't be able to put back together.

Ms. Harrison: What about the MOST team? Ms. Ruffin: The MOST team is funded by state grant money, so it won't be affected.

Ms Traveler: I wanted to see if I understood what you're saying. We need $46 million to stay where we are now. Then there is a 10% cut on top of that or an $8 million cut triggering a loss of $4 million in revenues.

This is just horrible. Then additionally to think that the day programs would be cut, when they provide such help for people. And knowing that there are people at SFGH now being held because there is no place to send them and it will only get worse. And the problem of the jails becoming mental health centers.

Mr. Shipley: I understand the predicament, but legally to be in compliance with the law which requires moving clients back into the community as soon as possible, and that opens the City to a lawsuit.

Ms. Ruffin: That's why this is so hard. There are certain things the Mental Health Director has to provide in jail services. We've done everything we can to bring in the revenue to pay for our programs. So cutting the General Fund hurts us more.

Ms. Harrison: A short time ago we had Proposition 36 with the people of California choosing to support treatment instead of jailing people. Why can't we do something like that for the City's programs. We did Proposition 36 within a year and a half.

Ms. Ruffin: A key question is: What is the mood of the country. I don't see a lot of interest in increasing social programs right now. As problems become clear that may change.

Ms. Brown: The cuts in the outpatient programs, will that mean that the OMI Family Center and Westside will be shut down? Ms. Ruffin: No. There will be reductions, but we've tried not to shut anything down. It'll depend on how much we have to cut, but those are exactly the kinds of outpatient programs we're talking about cutting to some extent.

Ms. Chartrand: Since September 11th, there has been a three- to fourfold increase in depression nationally. And then we don't want to do anything about increasing social services. I don't understand this. People are suffering. In my experience, people are being harassed, but they are just not coming forward with reports.

Why not create a proposal to put through to drug companies, which are making lots of money? Why not some kind of collaboration to generate income and money? Let's take the fat off some of these programs and have people collaborate on wrap around services. Let's cut out any duplication of services. There's money out there.

Mr. Douglas: I keep wondering if we could save money by consolidating a lot of these agencies, and I know they are wonderful agencies, but they have their own administration we are paying for. Could we save money by having the City provide these services?

Ms. Ruffin: There are some opinions out there that there are too many agencies with duplicative administration costs. I think we have done a lot through our contracting to cut back on duplication, but it's not a process that is over.

Mr. Dorsey: What about anthrax?

Ms. Ruffin: Part of our disaster plan includes strategies for dealing with suspicious mail, and we are available to work with the Postal Service. We did have a letter come here to 1380 Howard labeled as containing anthrax. We evacuated the building. We had it tested by the Department of Public Health lab and the result was negative.

Dr. Beauford: I'd like to commend you. I've been on the Board for 5 years, and the budget issue is one that we have always struggled with. I want to commend you and your staff on doing a wonderful job of focusing on consumer services in spite of all the cuts.

3.0 DIRECTORS REPORTS

3.1 Report from the Director of Community Mental Health Services

Budget Update. The projected budget deficit for the Department of Public Health for FY2002-03 is $56.6 Million; $26.0 Million for a 5.5% MOU civil service salary increase and $30.6 Million for a 10% reduction in General Fund revenue. To help deal with this deficit the Mayor's Office has instituted a selective hiring freeze on general fund positions and is not approving any upgrades for staff positions. The one-time add-back funds from the Board of Supervisors or the Mayor's Office will not be in the base budget for next year. The CMHS share of this reduction will be approximately $4.0 Million for the Base Budget and an additional reduction of $9 to 12 Million for the anticipated 10% General Fund reduction. Staff is now working on worst and best case budget scenarios.

Mental Health and Depression Screening. Joining efforts with the San Francisco Mental Health Association, our Cultural Competence Office coordinated the offering of mental health screenings for depression, bipolar disorder and PTSD at multiple community settings including: St. Anthony's Foundation Medical Clinic, San Francisco Free Clinic, Health Center III, Lady Shaw - Self-Help for the Elderly and several community health fairs. These offerings were provided in conjunction with National Depression Screening Day on October 11, 2001 and follow up community educational outreach activities in response to the September 11, 2001 disasters in New York, Washington, DC and Pennsylvania. Information was provided to more than 250 individuals visiting these sites and 123 individuals completed the screening protocols. Screenings were administered in English, Spanish and Chinese with assistance from staff of the Chinatown NorthBeach Integrated Services Center, Richmond Area Multi-Services, Inc., the South of Market-MOST Team, CMHS Access Team and our Primary Care Consultation Psychiatrists.

Multicultural Student Stipend Program (MSSP). Community Mental Health Services has awarded 21 Multicultural Student Stipends (MSSP) to graduate students placed throughout our mental health clinics and contract agencies for the academic year 2001-02. Stipend amounts vary from $1,000 to $2,900 per student. The selected recipients offer a breadth of cultural and linguistic skills as well as a rich experience and commitment to working with diverse client populations. The MSSP Program provides support to students with interest in working in public mental health services and in their development of skills to work with culturally diverse populations. The MSSP, now in its 13th year, is part of CMHS's ongoing human resources effort to increase the pool of applicants with special skills and knowledge, including language and cultural skills, for future employment with CMHS. More than one third of MSSP recipients become successfully employed in our system of care.

Nancy Presson. As most of you know Nancy Presson will be leaving at the end of January after more than 20 years of executive leadership in CMHS. Nancy's leaving will be a tremendous loss to the system. Among her other accomplishments Nancy was responsible for laying the groundwork for our widely recognized Children and Youth System of Care, overseeing the Municipal Bond process for the Mental Health Rehabilitation Facility and for the very successful transition of CMHS to the sole provider of specialty mental health services in San Francisco operating under a managed care model and responsible for the mental health care of all eligible residents. Nancy is leaving to pursue her long time interest in teaching at the elementary school level. We wish her the best of luck in her new endeavor.

Louise Rogers. Louise Rogers, who has served as the planner and risk manager for CMHS for the past seven years, is leaving to take another position. Louise was successfully recruited by San Mateo County Mental Health to be the Deputy Director of Operations. This is a significant and well-deserved step up for Louise in her career. Louise will be greatly missed in CMHS and in DPH. Louise was instrumental in a large number of innovations in CMHS. These included the transition to managed care and the successful design and implementation of the very successful Single Point of Responsibility programs. Everyone at CMHS can tell a story about how Louise has personally helped them. She will be missed by all.

3.2 Report from the Executive Director of the Mental Health Board

Ms. Brooke: The Board of Supervisors passed a resolution that mandates the Police Crisis Intervention Training. We testified at the Rules Committee. I went up to the microphone three times to ask for funding. They passed the resolution mandating the training, but there is no money that goes with it.

The San Francisco Police Department has cut the costs of the training from $90,000 to $30,000 by covering the back fill, which means paying for officers to fill in for those in the training, because they feel it is so valuable. So we are going to drug companies for the other funding. Most of the presenters are donating their time, and we're using mental health staff for much of the training. But there are still basic costs.

Ms. Chung: With regard to contacting supervisors about the budget, fax is best. And voice mail is better than e-mail because the Supervisors get spammed. Or you can mail your comments or hand deliver them to the Clerks office. Ms. Ruffin: It is really important to let the supervisors know what you are thinking. It may not feel like it sometimes. But a supervisor who has received 25 letters on something will view it differently than if they don't receive any.

4.0 MENTAL HEALTH BOARD COMMITTEES

4.1 Report of the Chair of the Board and Executive Committee

PROPOSED RESOLUTION (MHB-2002-04) Regarding priorities of the Mental Health Board for 2002.

Be it resolved that the Mental Health Board adopts the following as its priority areas of focus for 2002:

1) The consequences and aftermath of September 11th.
Including: Trauma and other mental health issues, demand for services, access to the system, quality of services, the Wellness and Recovery Model, immigration, and transition services.

2) Advocacy
Including: Meeting with supervisors, writing letters, networking, partnering with Community Mental Health Services, the Americans with Disabilities Act, cultural competency, and responding to legislative issues.

3) The City budget for mental health services.
Including: Monitoring the development of the budget, anticipating cuts and planning strategies for responding, working closely with CMHS, helping consumers deal with the changes. (Passed unanimously.)

Dr. Beauford announced the nominations for the election of officers at the February meeting of the Board for two-year terms. For Chair: Ted Stinson, for Vice Chair: Andrea Leung, for Secretary: Alex Kitzes. Kate Walker was recommended for the appointed position of State Liaison.

PROPOSED RESOLUTION (MHB-2002-05) Honoring Nancy Presson upon her retirement from Community Mental Health Services:

Be it resolved that the San Francisco Mental Health Board present the following award to Nancy Presson:

The Mental Health Board of San Francisco gratefully honors

Nancy Presson

For your total and absolute commitment to the best possible mental health services.
For being action-oriented and doing whatever it takes
to accomplish seemingly impossible goals.
For your reassuring calm in the midst of multiple, simultaneous crises.
For treating everyone with personal respect.
For being able to transcend and transform rigid regulations and rules
in order to get clients the treatment they need.
For your ability to grasp incredibly complex issues and explain them to us in understandable ways.
For your leadership in the funding and building of
the Mental Health Rehabilitation Facility.
For doing the ground work on the Children's System of Care.
For your warmth, creativity, graciousness, sense of humor,
and the maturity of your leadership.

We admire and applaud the choice you have made to become
an elementary school teacher,
but we will miss you dearly.
(Passed unanimously.)

4.2 Children's Committee

Dr. Beauford, We're still moving forward on our meeting with Arlene Ackerman.

4.3 Cultural Competency

Ms. Leung: We will probably will be spending a fair amount of time on a media strategy for reaching the minority community. We are working on how to implement this, but I think this will be one of the main focuses this year.

4.4 Program and Services

Mr. Shipley: We came up with a resolution opposing AB 1421, (see Attachment D). It's quite lengthy. We hope to send this on to the Health Commission and on to the Board of Supervisors. It's been quite a lengthy process.

Presentations were then made pro and con on this resolution as follows:

Mr. Stinson: I'd like to begin by saying that this is a very difficult topic, and I want to commend my fellow Board members on the Program and Services Committee for having a very amicable discussion and for an atmosphere of mutual respect. I would like to present some arguments for voting against the resolution and in favor of the legislation.

As most of you know, the resolution is regarding involuntary outpatient treatment. I come from a family-member perspective. My mother had a fairly severe case of schizophrenia. As I thought through my own perspective on this bill and the underlying issues, I asked myself is there a population in the state of California for whom involuntary outpatient treatment would be good. If you look at the research, you find that there are probably several thousand people for whom the answer is yes.

By the evidence of the McArthur Research Network, there are people who are not able to make treatment decisions for themselves.

So the question becomes: Is involuntary outpatient treatment valuable for that group? The evidence is not strongly in support or against. A study by Duke University, though, shows that involuntary outpatient treatment can be effective.

Any time you start thinking about people's civil liberties, the bar has to be very high, and due process has to be in place. It's important to err on side of caution. That, to my best of understanding was one of the reasons the bill wasn't passed last year. So it was revised. It's supported by the two major papers of California. It passed out of subcommittees and has the support of Carole Migden. I have more comfort that the civil rights issues have been addressed. When we look at other states with similar legislation, they are not misusing it.

Kendra's law in New York, forecast several thousand people would be ordered into involuntary outpatient treatment, and it has only been several hundreds.

Based on these reasons, I'm in support of AB 1421 and opposed to this resolution before the Board.

Ms. Walker: On your point that there may be people who need treatment and may not be able to get it, the current LPS law does take care of that. For instance in the case of a diabetic who does not give consent to treatment, the LPS law gives the hospital the right to give treatment to someone who is going to die without it.

I do not share your comfort in settling civil liberty questions. I have two problems with the act as it's stated now. If due care has been taken to find the person who is the subject of a petition and that person has not been found, that person can be committed in camera, in the courtroom, without his knowledge. He should have a chance to defend himself.

This is a legal procedure; it goes before the court. If the poor guy decides to fight it and not cooperate, then he is made into a criminal because he has disobeyed a court order.

Since nobody can give a definition of what insanity is, since the medications people are given do vast damage to the body, I say that people should have a choice whether they wish to try to get the benefits of the treatment. But if there are people who do not get benefits from the treatment, they should not be forced to take it.

Dr. Beauford: This issue has been before this Board for a long time. I thought when I saw this on the agenda, that it could be a Board meeting in and of itself. I would like to recommend that you table it and discuss it at the next Board meeting. I think new members need to handle this issue, especially something that will have such significant impact on clients.

Dr. Kitzes: If this is the level of discussion and thoughtfulness we'll be having, the Board is in good hands. Both of you, Ted and Kate, are very impressive. And the respect with which you hold each other is impressive.

Ms. Traveler: We've had great leadership on AB 1421 with Mickey Shipley, and he has brought us through some difficult waters. What he has brought to the table through our many discussions has been very helpful. I would not like to see this gone.

Mr. Stinson: I'd recommend discussing this at the next Program and Services Committee.

Mr. Shipley: We've been dealing with this for 3 years. IThe bill has had 3 different numbers, but it's the same thing for 3 years with some minor changes. If this Board has not been educated enough in those years, another month won't do it. We need to move now and soon, because it's coming to a vote in the legislature.

Dr. Beauford: I'd like to propose tabling it.

> **RESOLUTION (MHB-2002-06): Be it resolved that the issue of AB 1421 be tabled until the February meeting. (Passed with all yes votes, with the exception of an abstention by Mr. Shipley.)**

5.0 PUBLIC COMMENT

Mr. Kalman commented on AB 1424 and AB 1421, saying: I think in some case we need to have it, if the person can not decide for himself. Why should we wait until the person is a danger to himself. I want to thank all the members on the Board.

Mr. Agar: I want to voice that it's been an extraordinary blessing for me to be part of this body. It's bittersweet to be leaving this Board. I'd encourage the new members to take the time to immerse yourselves in learning about the system. Jo has done extraordinary things in the last 18 months to educate us on the system, and having her staff bring us presentations to help us understand a very complex, very large, very challenging system. I'd encourage you to hang in there; it doesn't come in 6 months or a year, but in 18 months or 2 years you will become very effective. Be patient with yourselves. And to my fellow Board members: it has been a sincere pleasure.

Ms. Traveler: A responsibility we have in serving on this Board is to get out to the people that we're talking about. We have all the labels; we have all that stuff. But we're talking and advocating for human beings. I've learned so much. I've been able to be a support to my sister who has been involved with her mental illness for the last 30 years. This has been so wonderful to be on the Board, the people, the concern, the heart. Thank you, everyone, for your support!

Mr. Shipley: I don't make speeches very well, so bear with me. I've been on this Board almost 5 years. I have worked with various people who have come and gone. It has been a pleasure working under two executive directors and one steadfast administrator, along with members of the public and other members who have sat on this Board. I am an advocate. I will be an advocate till the day I die. I'm not going away. I want to offer my knowledge and my mentorship, to help you in your advocacy for consumers and family members.

Dr. Beauford: Thank you to the Board and the members who are leaving. It was a privilege to serve with you. It was fun. Whether the discussion was heated or not it was fun. I enjoyed it. We will be in contact and keep in contact.

There being no further business, the meeting was adjourned at 8:45 p.m.

SAN FRANCISCO MENTAL HEALTH BOARD

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MEETING OF THE MENTAL HEALTH BOARD

Wednesday, February 13, 2002
1380 Howard, Room 537
6:30 p.m.

AGENDA

Public comments will be taken for each agenda item.

1.0 CALL TO ORDER AND CONSENT CALENDAR (10 minutes)

For discussion and proposed action

02-13-02A10:47 RCVD

1.1 Call to Order and Announcements from the Chair

1.2 Election of Officers

Presentation of Nominations of officers for the Mental Health Board. Nominations by the Nomination Committee are: Chair: Ted Stinson, Vice Chair: Andrea Leung, Secretary: Dr. Toye Moses.

1.3 Consent Calendar (Attachment A)

1.3.a PROPOSED ACTION: Resolution that the Board approve the See: ↓ minutes of the MHB meeting on January 9, 2002.

1.3.b PROPOSED ACTION: Resolution approving leaves of absence of Dr. Toye Moses and Andrea Leung for the MHB meeting on February 13, 2002.

2.0 PRESENTATION: JO RUFFIN, Director of Community Mental Health Services BUDGET STRATEGIES (50 minutes)

Jo Ruffin will lead a discussion about planning strategies for responding to the proposed budget cuts and identification of other resources that might be available to meet individual needs.

3.0 DIRECTORS REPORTS (30 minutes)

For discussion

3.1 Report from the Director of Community Mental Health Services
A report on the activities and operations of Community Mental Health Services, including budget, planning, policy, and programs and services.

3.2 Report from the Executive Director of the Mental Health Board
A report including updates and announcements regarding the activities and operations of the Board.

4.0 MENTAL HEALTH BOARD COMMITTEES (20 minutes)

For discussion and proposed action

4.1 Report of the Chair of the Board and Executive Committee
The chair will report discussions and actions of Executive Committee.

4.1.a PROPOSED ACTION: Resolution that the Mental Health Board urges the Mayor and the Board of Supervisors to responding to the Budget Crisis with a Comprehensive Revenue Strategy. (Attachment B)

4.2 Children's Committee
No report

4.3 Cultural Competency & Special Populations Committee
No report

4.4 Program and Services Committee
No report

4.4.a PROPOSED ACTION: Resolution that the Mental Health Board urges the Mayor and the Board of Supervisors to oppose AB 1421, Mental Health, Involuntary Outpatient Treatment. (Attachment C)

4.5 State Liaison
A report on developments regarding mental health services, policy, and funding at the state level, including the California legislature, the State Department of Mental Health, and other statewide advocacy or policy organizations.

5.0 PUBLIC COMMENT (10 minutes)

This is an opportunity for members of the public to address the Mental Health Board on items of interest to the public that are within the subject matter jurisdiction of the Mental Health Board. Additionally, public comments will be taken for each agenda item.

This agenda and all attachments can be viewed at: www.ci.sf.ca.us/mental_health. Attachments are also available at the Mental Health Board Office, 1380 Howard Street, Suite 510, telephone 255-3474.

DISABILITY ACCESS

1. American Sign Language interpreters and/or a sound enhancement system will be available on request. Please contact Ladonnis Elston at (415) 255-3444 (voice) or (415) 255-3449 (TTD) 5 days before the meeting. Large print copies of the agenda will be made available upon request; please call (415) 255-3474.

2. Meetings are held at 1380 Howard Street (corner of 10th Street), in Room 537. The closest accessible BART station is the Civic Center station, at the intersection of Market, Grove and Hyde Streets. The closest Muni Metro station is the Van Ness Station. Accessible MUNI lines serving the location are the 9 San Bruno, 47 Van Ness, and the 72 Haight/Noriega. For more information or updates about the current status of MUNI accessible services, call (415) 923-6142. For information about Paratransit Services call (415) 351-7000.

3. The main entrance to 1380 Howard is accessible to wheelchairs. Elevators, doorways, restrooms, and the meeting room are wheelchair accessible. Accessible curbside parking has been designated on Grace Alley which runs on the opposite side of the building from 10th Street.

4. In order to assist the City's efforts to accommodate persons with severe allergies, environmental illnesses, multiple chemical sensitivity or related disabilities, attendees at public meetings are reminded that other attendees may be sensitive to various chemical based products. Please help the City accommodate these individuals.

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The ringing of and use of cell phones, pagers, and similar sound-producing electronic devices are prohibited at this meeting. Please be advised that the Chair may order the removal from the meeting room of any person(s) responsible for the ringing or use of a cell phone, pager, or other similar sound-producing electronic devices.

KNOW YOUR RIGHTS UNDER THE SUNSHINE ORDINANCE

Government's duty is to serve the public, reaching its decisions in full view of the public. Commissions, boards, councils and other agencies of the City and County exist to conduct the people's business. This ordinance assures that deliberations are conducted before the people and that City operations are open to the people's review. For more information on your rights under the Sunshine Ordinance (Chapter 67 of the San Francisco Administrative Code) or to report a violation of the ordinance, contact:

Donna Hall
Sunshine Ordinance Task Force
City Hall, Room 244
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102-4689
Telephone: (415)554-7724
Fax: 4(15) 554-5163
E-mail: Donna_Hall@ci.sf.ca.us

Citizens interested in obtaining a free copy of the Sunshine Ordinance can request one from Ms. Hall, or by printing Chapter 67 of the San Francisco Administrative Code from the internet at: **www.ci.sf.ca.us/sunshine.htm**

To view Mental Health Board agendas and minutes, you may visit the MHB web page at: **www.ci.sf.ca.us/mental_health**. You may also go to the Government Information Center at the Main Library at Larkin and Grove in the Civic Center. You may also get copies of these documents through the MHB office at 255-3474.

Lobbyist Registration and Reporting Requirements
Individuals and entities that influence or attempt to influence local legislative or administrative action may be required by the San Francisco Lobbyist Ordinance [SF Campaign & Governmental Conduct Code 2.100] to register and report lobbying activity. For more information about the Lobbyist Ordinance, please contact the San Francisco Ethics Commission at 30 Van Ness Avenue, Suite 3900, San Francisco, CA 94102; telephone (415) 581-2300; fax (415) 581-2317; web site www.sfgov.org/ethics.

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MENTAL HEALTH BOARD
ATTACHMENT A
February 13, 2002

CONSENT CALENDAR

All items on the Consent Calendar are handled through a single vote. There will be no discussion unless a member requests it, in which case the item will be removed from Consent Calendar and discussed. Additional names may be added to the leave of absence resolution during the meeting.

1.2.a **PROPOSED RESOLUTION: Be it resolved that the** See: ↓ **minutes of the Mental Health Board meeting of January 9, 2002, be approved as submitted.**

1.2.b **PROPOSED RESOLUTION: Be it resolved that the Mental Health Board grants leaves of absence for the meeting of February 13, 2002, to the following members: Andrea Leung, Dr. Toye Moses.**

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MENTAL HEALTH BOARD
ATTACHMENT B
February 13, 2002

PROPOSED RESOLUTION (MHB-2002-xx): RESPONDING TO THE BUDGET CRISIS WITH A COMPREHENSIVE REVENUE STRATEGY

WHEREAS, in the wake of the tragic events of September 11, 2001, local, state, and national economies have taken a significant downturn; and

WHEREAS, the City and County of San Francisco is facing a decline in revenue which in turn is threatening a potential 10% cut in services; and

WHEREAS, these cuts mean a crucial loss of services for individuals in the short-term; and

WHEREAS, these cuts will cause the City to lose experienced staff during a time when it is already very difficult to recruit qualified staff due to the cost of living in our City; and whereas staff who are laid off may be lost to our system permanently; and

WHEREAS, any treatment sites and service facilities which have to be closed down during the current crisis, may be impossible to re-establish in a future year depending on the real estate market; and,

WHEREAS, the users of the City's public health and human service systems are, in a sense, secondary victims of the attack of September 11th, and whereas the City itself is a secondary victim, in that its infrastructure of services is in being put in jeopardy, and

WHEREAS, the Mental Health Board further believes that a strong and effective public health system directly benefits all neighborhoods and economic sectors of the community; and

WHEREAS, the Mental Health Board believes that our community has a moral duty to care for those people who are ill, suffering, in trouble, and in need, now, therefore,

BE IT RESOLVED, that the Mental Health Board urges the City and County of San Francisco to respond to this crisis with a comprehensive revenue strategy, not just a cutting strategy, and to do a thorough and comprehensive review of all the City's revenue sources, on an emergency basis, to make sure that all property assessments, utility fees, cable fees, and other revenues are being collected fairly and completely, that loopholes are closed, that any under-assessments are brought into line with true market value, and that fees which have been historically low are brought up to date; and

BE IT FURTHER RESOLVED, that the Mental Health Board recommends that the City and County of San Francisco do everything in its power to protect the long-term investment it has made in its services, so permanent damage is not done, and to take all necessary steps to preserve and defend the vital, state-of-the art services the city has developed through years of intensive effort, and

BE IT FURTHER RESOLVED, that the Mental Health Board recommends that the City and County of San Francisco, realizing that San Francisco is still one of the wealthiest cities in the world, and realizing that these are extraordinary times requiring extraordinary solutions, be assertive about instituting fair and progressive revenue increases, and

BE IT FURTHER RESOLVED, that the Mental Health Board recommends that the City and County of San Francisco, through such a revenue strategy, do everything in its power to fund the base line budget of the Department of Public Health with the inclusion of a COLA for the contractors, and to prevent the threatened 10% reduction, and

BE IT FURTHER RESOLVED, that the Mental Health Board recommends that the City and County of San Francisco continue to lobby strongly for parity in mental health care so that the public mental health system is not having to take clients who should rightly be covered by private insurance companies, and continue to lobby for health coverage for all citizens, thereby lessening the burden on municipal public health systems due to the numbers of uninsured or underinsured citizens, and

BE IT FURTHER RESOLVED, that the Mental Health Board urges the City and County of San Francisco to lobby strongly at the national level for tax policies which create a vigorous economy by focusing any financial stimulus on the middle class, the working class, and the poor, rather than further promoting a concentration of wealth in fewer and fewer hands.

DPH

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(Minutes)

DISCUSSION NOTES
Mental Health Board
Wednesday, February 13, 2002
1380 Howard Street, Room 537
San Francisco, CA 94103
9:00 a.m.

BOARD MEMBERS PRESENT: Ted Stinson; (Chair); Bridgett Brown; Bob Douglas; Carol Knight; Rose Chung for Supervisor Aaron Peskin; Kate Walker.

BOARD MEMBERS ON LEAVE: Alex Kitzes, Ph.D.; Andrea Leung, L.C.S.W., A.C.S.W.; Toye Moses, Ph.D., M.P.H., Dennis Yun.

BOARD MEMBERS ABSENT: none.

OTHERS PRESENT: Jo Ruffin (CMHS Director); Mickey Shipley (San Francisco Network of Mental Health Clients); Dorothy Shaffer (Parent); Deborah Sanders; Augusta Del Zotto (California Human Development Corporation); Tiffeny Jimenez (Psych major, SFSU); Idell Wilson; Emeric Kalman; Helynna Brooke (MHB Executive Director); Rich Snowdon (MHB Administrator)

PLEASE NOTE
There was no quorum for this meeting of the Mental Health Board, therefore no action items were considered and no votes were taken.

The discussion started at 6:38 p.m.
Mr. Stinson: Andrea and Toye had prior commitments for tonight. Dennis and Alex are sick. So we have no quorum for our meeting. But by the March meeting we expect to have enough new Board members appointed so that there will be no problem with having a quorum.

This means we will not be able to elect officers tonight. Our outgoing Chair, Jim Beauford, appointed me to serve as Acting Chair until such time as we are able to hold our election.

I'd like to ask the slate of officers, Andrea and Toye, along with Kate as our State Liaison, to serve as the Acting Executive Committee, and to meet on Thursday, February 28, at 6:30 p.m., to plan the March meeting. All other Board members and members of the public are very welcome to attend.

There are several people here who are candidates for being appointed to the Board and I'd like to ask them to introduce themselves.

Dorothy Schaffer
I'm the parent of a 14-year old. I'm applying for a Family Member seat. I go to the Family Involvement Team meetings. My thought is that there is a component missing about children and mental health. I think I have experienced just about everything you can experience as a parent. I want to look at how services can be connected, and how I can help others connect. Every day I'm astounded to learn about services that are there that we didn't connect with because of different reasons. I'm a nurse practitioner and work for the Oakland School District. I know I make a difference for parents, just from the experiences I've been through. If I'm appointed to the Board, you'll get my health care background and parent background. I see every day in my own family and when I go to work, how mental illness affects the whole family. And how hard it is to get everyone on the same page.

Augusta Del Zotto
I'm the Director of the Center for Human Development, which has been associated with the San Francisco School District for 35 years. I'm an advocate for youth needs. Some of the issues we focus on in terms of mental health, include: the high increase in post traumatic stress disorder, youth in violent communities, and youth coming from violent situations abroad. We're also concerned with gay and lesbian youth issues, especially in minority communities. I have a doctorate in Public Administration, and am the co-founder of the Latino AIDS Project. I've been on the Board of Instituto Familiar de la Raza for years.

Deb Sanders
I'm applying for a Consumer seat on the Board. I would be coming with an advocacy point of view and consumer point of view. I was hospitalized as recently as 2001. My advisor is Peter Forster, who was the Medical Director of CMHS. I have been Chair of the Disability Rights Committee at the BAR Association. I'm active in educational programs on legislation. I was a student in the doctor of mental health program at Berkeley when it was started in the 70's. I have been very active in mental health and mental retardation issues. I have been active with ARC and with NAMI, and as an independent advocate. This year I received the 2001 Exemplary Family and Patient Advocacy Award from the California Psychiatric Association.

Idell Wilson
I am a consumer and an advocate. I run a club at City College for students with disabilities, and we focus on learning disabilities. This would be my first time on a Board. I'm also an AmeriCorps Vista volunteer at the Bay Area Homeless Program at San Francisco State University and work with Roma Guy of the Health Commission.

Another member of the public introduced herself: I'm Tiffeny Jimenez, a psychology major at San Francisco State University. I've just finished an internship at Community Focus. I'm coming to the meeting because I want to find out what's going on in CMHS.

Mr. Stinson: It's really exciting to hear that there are so many qualified candidates applying for the Board.

BUDGET PRESENTATION BY JO RUFFIN, DIRECTOR OF COMMUNITY MENTAL HEALTH SERVICES.

Ms. Ruffin: Thank you for this invitation.

There is a projected deficit of $56 million, in part because we have to absorb $26 million COLA for the unions. In our base budget those costs are covered with revenue. In mental health, we have $4 million in extra revenue.

However, in the base budget, there is no COLA for contract agencies in the Department of Public Health. That's an important issue in mental health because about 70% of our services are contracted out. When those agencies don't get a COLA, that translates into reduced services.

Then in addition to the deficit I just mentioned, the Mayor's Office is asking for a budget with a 10% reduction. This is due to the reduction in airport and hotel taxes, since fewer people are traveling since September 11th.

What the Department is hoping is that we will not have to take the 10% cut, but we have drawn up a plan in case we do have to take it.

The Coalition on Homelessness has a Substance Abuse Mental Health Work group, which has been advocating for a couple years to have a drop in center for evenings and weekends. We don't have anything like this for adult services. We have a Mobile Crisis Team that only operates for part of the day. We tried to get money from the state to increase the hours for Mobile Crisis, but because of state cut backs, we weren't able to get that approved. We are putting forward this proposal for a drop in center.

The Director's written report was distributed:

Budget Update. The projected budget deficit for the Department of Public Health for FY2002-03 is $56.6 million; $26.0 million for a 5.5% MOU civil service salary increase and $30.6 million for a 10% reduction in General Fund revenue. The CMHS share of this reduction is approximately $4.0 million for the Base Budget and an additional reduction of $8 to 12 million for the anticipated 10% General Fund reduction. CMHS has submitted budgets to the department for best and worst case scenarios. The first Health Commission hearing on the budget was held on February 5, 2002. The final budget and any associated cuts will probably not be known until late April.

Drop-In Center Planning. CMHS has for a number of years worked to build a continuum of care that focuses on providing services in the community at the lowest and least restrictive level of care in order to minimize the use of higher levels of care such as psychiatric emergency services and inpatient hospitalization. Nevertheless, CMHS and the community have identified a serious gap in the continuum at the level of non-residential 24-hour services. Individuals who experience psychiatric crises after hours are dealt with by the police, and when necessary are taken to the hospital.

A planning process for a CMHS Drop-In center was initiated jointly by CMHS Administration and the Mental Health Board in November, 2001.The decision was made to move ahead with this planning process even though the funds advocated for by the Coalition's Mental Health and Substance Abuse Workgroup and made available by the Board of Supervisors for this fiscal year were reduced to $200,000; and there are no funds allocated in the future because of the current fiscal situation in the City. Those who participated in the planning process were consumers, mental health staff, representatives from current drop-in centers throughout the City, members of the Coalition on Homelessness, Mental Health and Substance Abuse Workgroup members and representatives from various other community stakeholder groups.

The planning group arrived at a proposal for the drop-in center (copies are available) that would seek to achieve the following outcomes developed by the planning group.

- Decreased police intervention in acute mental illness episodes and involuntary (5150) hospitalization
- Reduced utilization of Psychiatric Emergency Services
- More crisis episodes that are ìnippedî in bud or treated early
- Availability of psychiatric medication for clients already on anti-psychotic medication, those needing to start anti-psychotics, or for acute anxiety
- Decrease the number of homeless deaths and/or psychiatric related deaths
- Decrease number of deaths by legal intervention (ìsuicide by copí)
- Save money by reduce hospital and emergency costs and utilization
- Decrease the number of 5150s and involuntary commitments, and incarcerations in jails
- Increase the number of successful links to mental health services
- Increase the number of consumers who are actively engaged in treatment
- Increasing the flexibility and variety of services in the community-based safety net

In order to achieve these outcomes the planning group decided that the following essential services should be provided:

Program Structure

- After-hours services—the program could minimally be located at an existing service site for evenings, nights and weekends, or maximally be a stand-alone program with 24-hour/7-day a week services.
- Peer counseling and self-help is essential to increase the ability of the staff and program to establish a link to potential clients and start the engagement process.
- Access to psychiatric medication for clients already on anti-psychotic medication, those needing to start anti-psychotics, or for acute anxiety.
- Welcoming and supportive—the physical and social environment needs to be welcoming and supportive and clients need to be able to feel safe and secure.
- Easily accessible location—the location needs to be one that is easily accessible to most potential clients by foot or bus.

Staffing Characteristics

- Crisis intervention and stabilization—professional and peer staff need to be professionally trained in crisis intervention and stabilization.
- Physicians and nurses and case management—medical staff are necessary for proper assessment and the administration of medications.

- Culturally competent services/staff/volunteers—all staff connected to the program need to be culturally competent.
- Prepared for crises—the staff must be trained in crisis de-escalation techniques and any other techniques, which minimize the need for police or other control measures.
- Specific focus on the homeless culture—staff must be trained and experienced in the culture of those who are homeless and living on the streets.
- Peer staff and licensed clinical staff—an appropriate and balanced staff mix is critical to the program and includes both paid and volunteer staff who are both professional and peer trained.
- Harm Reduction service model—the program must be fully committed to a harm reduction model that emphasizes working with clients "where they are at" and seeking to reduce potential harm through a variety of strategies.

Two financing options are proposed for the center. The first option would fund the center for after-hours only (5 p.m. to 7 a.m.)—7 days a week, and the second option is for 24-hour/7 days a week funding.

Although the proposed center would make a major contribution to filling a blatant gap in the continuum of care, CMHS also may not request funds for new services without comparable revenue, as well as not requesting new civil service positions. Therefore, this proposal is not being presented by CMHS for funding. Further CMHS would not recommend further program reductions in order to fund this proposal. However, the Coalition on Homelessness may decide to bring the proposal forward to the Health Commission.

Sai-Ling Chan-Sew Appointment. Sai-Ling Chan-Sew, the director for the Child, Youth and Family Section of Community Mental Health Services has been appointed to the Healthy Families Program Advisory Panel, as a mental health representative, beginning in February 2002. The Healthy Families Program provides health, dental and vision insurance to children with eligible family incomes. The Healthy Families Program is overseen by the Managed Risk Medical Insurance Board. The Advisory Panel provides recommendations to the Board on key program issues.

Ms. Ruffin: Now let's take a closer look at the budget proposals. Our ongoing plan in mental health is to minimize use of the institutional level of care, such as Napa State Hospital, inpatient units, private hospitals, and Psychiatric Emergency Services (PES).

We're trying to keep people from entering the system at PES. We want to get to them early. We might visit them at their home and get them into a clinic. One of the values of the drop in center, is that people could go there instead of having the police called.

In the children's system the same is true. We are trying to divert children and youth away from emergency treatment. We are trying to shift resources to commmunity-based, non-crisis treatment, and prevention programs.

We maximize our revenues. When the Department has to cut $30 million out of a total of $304 million in General Fund money for DPH, that's divided between SFGH, Laguna

Honda, and the communjity programs. CMHS is the biggest part of the community programs. We had to cut $ 8 million, but that meant we would lose an additional $4 million in revenue for a total cut of $12 million.

Here's an overview of the cuts being proposed for Community Mental Health Services:

Napa State Hospital.
We've been cutting Napa beds for years. Unfortunately we haven't been able to move those funds to community programs. This year we had to take the forensic clients. So we had to buy additional beds. Each bed is 100,000 a year per bed and we paid for 8 beds.

Locked units and neurobehavioral health.
We're projecting a cut of $2.8 million.

Private Hospitals: St. Mary's, St. Francis, St. Luke's, and CPMC
The cut here was $2.7 million.

Residential treatment.
We decided the Acute Diversion Units were important to keep. We opened a new one this last year and the number of hospitalizations at SFGH dropped by 10%. So the ADU's work.

Transitional residential treatment.
These provide 60-90 days of teatment. Purely based on the cost of services per client served, we wiped out all our transitional residential treatment, including La Mistad, Baker, and Odyssey, for a cut of $4 million.

Day Treatment.
We eliminated all our day treatment except for the day treatment programs connected with the ADU's.

Outreach.
We're proposing $250,000 in cuts.

Outpatient services.
We're proposing $750,000 in cuts.

Private provider network.
We're proposing a $580,000 cut.

We decided not to cut any supported housing services or case management services. We are not cutting any consumer-run programs.

We have a huge equity investment in our treatment facilities. Most of them were established in the 60's and 70's and we're benefitting from that. If we lost them, we couldn't replace them in the current real estate market.

It's being proposed that 30 beds be cut from the Mental Health Rehabilitation Facility at SFGH for a reduction of $2 million.

Jail Psych Services are targeted for a huge cut, which will wipe out about 2/3 of those services.

With all the cuts it's making, the Department was still not able to achieve the goal of cutting $30 million. DPH is submitting proposed cuts of about $25 million and about half that is in mental health.

Mr. Douglas: What happens to the patients when you cut locked beds?
Ms. Ruffin: There's no good answer to that question. If all these cuts were taken, our system would need to be re-designed. It's an almost impossible cut to take. But we have to look at the number of patients being served. Do we send 30 patients out or several thousand? That's the dilemma.

Ms. Brooke: Is it possible that many of those people would end up in the criminal justice system? Ms. Ruffin: Yes, that would be likely. But they wouldn't get services in the jail, if Jail Psych is also cut. Many would end up in hospital emergency rooms.

The Department of Public Health does not want these cuts to happen, but we have to follow the instructions of the Mayor's Office.

State revenue reductions will have a little effect, but not alot, on mental health, which is fortunate. Our state mental health funding is tied to specific licensing taxes.

Mr. Stinson: One of the sad ironies of these budget cuts is that they end up costing other departments more money. If we are cutting $12 million here at CMHS, what is the impact on other Departments?

Ms. Ruffin: Immediately the costs go up, because clients would be stuck on inpatient units and unable to move to lower level services. There would be an increase in police costs and services as well as Emergency Room services. There would be increased jail costs. There would be an impact on the shelter system and an increase of homelessness on the streets.

Mr. Stinson: Is this interconnectedness understood by the people making the decisions? Because with the increased costs, there really is no budget cut. That's actually a myth.

Ms Ruffin: I don't think it's well understood. Some people think because you see people out on the streets who are mentally ill, that mental health services don't work. That's not true. The services do work. Without us there would be many more people out on the streets.

Mr. Shipley: The cuts are going to put people out on the street unprotected. We're going to see an increase in homelessness. Is there any other area in the mental health plan that possibly could be cut or sacrificed rather than services to the consumers?

Ms. Ruffin: We looked at everything we had. The services we did protect were case management, consumer run services, and vocational services. I don't have infrastructure in my budget. I've lost Nancy and Louise last month and now those two positions are frozen. Colllins' position was lost in a prior cut.

Mr. Stinson: Thank you for this presentation. It's been very sobering, but it will help us as we go out to talk to the Supervisors and others.

PUBLIC COMMENT

Ms. Sanders: I'd like to explain that I do not think that San Francisco General Hospital and Laguna Honda should have their funding cut. But I think it is important to have advocacy to reach people in their most scared moments. People do not sympathize with our mental health population like they do with people with medical problems. Somatic illnesses affect almost everybody in their life time, so those illnesses get the public's sympathy.

CMHS is only 10% of the DPH budget, but is taking 45% of cuts. I believe as a tactic, we should say that DPH should take monies out of everything else. I'm not saying it's right, but as a tactic I think it makes sense.

Ms. Shive: I'm an advocate with the Mental Health Association of San Francisco. I'm very interested in the work of the Board. My sister is warehoused in prison right now. So many people are introduced to the mental health system through the criminal justice system. According to a new report, 30% of people in jails are people with mental illness who have committed no crimes, but they are being treated as criminals.

We already don't have adequate psychiatric services in the jails and the fact that these services are going to be cut is abhorent to me. I'm very encouraged by the turnout at this meeting and by this discussion.

The discussion was brought to a close at 8:10 p.m.

DPH

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MEETING OF THE MENTAL HEALTH BOARD

Wednesday, March 13, 2002
1380 Howard, Room 537
6:30 p.m.

AGENDA

Public comments will be taken for each agenda item.

1.0 CALL TO ORDER AND CONSENT CALENDAR (10 minutes)

For discussion and proposed action

1.1 Call to Order and Announcements from the Chair

1.2 Election of Officers

Presentation of Nominations of officers for the Mental Health Board. Nominations by the Nomination Committee are: Chair: Ted Stinson, Vice Chair: Andrea Leung, Secretary: Dr. Toye Moses.

1.3 Consent Calendar (Attachment A)

1.3.a PROPOSED ACTION: Be it resolved that the minutes of the Mental Health Board meeting of January 9, 2002, be approved as submitted.

1.3.b PROPOSED ACTION: Be it resolved that the Mental Health Board grants leaves of absence for the meeting of February 13, 2002, to the following members: Andrea Leung, Dr. Toye Moses.

1.3.c PROPOSED ACTION: Be it resolved that the discussion notes of the Mental Health Board meeting of February 13, 2002, be approved as submitted.

1.3.d PROPOSED ACTION: Be it resolved that the Mental Health Board grants leaves of absence for the meeting of March 13, 2002, to the following members: Bridgett Brown.

2.0 DIRECTORS REPORTS (30 minutes)

For discussion

2.1 Report from the Director of Community Mental Health Services
A report on the activities and operations of Community Mental Health Services, including budget, planning, policy, and programs and services.

2.2 Report from the Executive Director of the Mental Health Board

A report including updates and announcements regarding the activities and operations of the Board.

3.0 PRESENTATION: ADVOCACY WORKSHOP

Campaign for mental health. Strategies and templates for successfully advocating for mental health. Speaker TBA.

4.0 MENTAL HEALTH BOARD COMMITTEES (20 minutes)

For discussion and proposed action

4.1 Report of the Chair of the Board and Executive Committee

The chair will report discussions and actions of Executive Committee. Discussion regarding committee structure.

4.1.a PROPOSED ACTION: Resolution that the Mental Health Board urges the Mayor and the Board of Supervisors to responding to the Budget Crisis with a Comprehensive Revenue Strategy. (Attachment B)

4.2 Children's Committee

No report

4.3 Cultural Competency & Special Populations Committee

No report

4.4 Program and Services Committee

No report

4.4.a PROPOSED ACTION: Resolution that the Mental Health Board urges the Mayor and the Board of Supervisors to oppose AB 1421, Mental Health, Involuntary Outpatient Treatment. (Attachment C)

4.5 State Liaison

A report on developments regarding mental health services, policy, and funding at the state level, including the California legislature, the State Department of Mental Health, and other statewide advocacy or policy organizations.

5.0 PUBLIC COMMENT (10 minutes)

This is an opportunity for members of the public to address the Mental Health Board on items of interest to the public that are within the subject matter jurisdiction of the Mental Health Board. Additionally, public comments will be taken for each agenda item.

This agenda and all attachments can be viewed at: www.ci.sf.ca.us/mental_health. Attachments are also available at the Mental Health Board Office, 1380 Howard Street, Suite 510, telephone 255-3474.

DISABILITY ACCESS

1. American Sign Language interpreters and/or a sound enhancement system will be available on request. Please contact Ladonnis Elston at (415) 255-3444 (voice) or (415) 255-3449 (TTD) 5 days before the meeting. Large print copies of the agenda will be made available upon request; please call (415) 255-3474.

2. Meetings are held at 1380 Howard Street (corner of 10th Street), in Room 537. The closest accessible BART station is the Civic Center station, at the intersection of Market, Grove and Hyde Streets. The closest Muni Metro station is the Van Ness Station. Accessible MUNI lines serving the location are the 9 San Bruno, 47 Van Ness, and the 72 Haight/Noriega. For more information or updates about the current status of MUNI accessible services, call (415) 923-6142. For information about Paratransit Services call (415) 351-7000.

3. The main entrance to 1380 Howard is accessible to wheelchairs. Elevators, doorways, restrooms, and the meeting room are wheelchair accessible. Accessible curbside parking has been designated on Grace Alley which runs on the opposite side of the building from 10th Street.

4. In order to assist the City's efforts to accommodate persons with severe allergies, environmental illnesses, multiple chemical sensitivity or related disabilities, attendees at public meetings are reminded that other attendees may be sensitive to various chemical based products. Please help the City accommodate these individuals.

POLICY ON CELL PHONE, PAGERS, AND ELECTRONIC DEVICES

The ringing of and use of cell phones, pagers, and similar sound-producing electronic devices are prohibited at this meeting. Please be advised that the Chair may order the removal from the meeting room of any person(s) responsible for the ringing or use of a cell phone, pager, or other similar sound-producing electronic devices.

KNOW YOUR RIGHTS UNDER THE SUNSHINE ORDINANCE

Government's duty is to serve the public, reaching its decisions in full view of the public. Commissions, boards, councils and other agencies of the City and County exist to conduct the people's business. This ordinance assures that deliberations are conducted before the people and that City operations are open to the people's review. For more information on your rights under the Sunshine Ordinance (Chapter 67 of the San Francisco Administrative Code) or to report a violation of the ordinance, contact:

Donna Hall
Sunshine Ordinance Task Force
City Hall, Room 244
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102-4689
Telephone: (415)554-7724
Fax: 4(15) 554-5163
E-mail: Donna_Hall@ci.sf.ca.us

Citizens interested in obtaining a free copy of the Sunshine Ordinance can request one from Ms. Hall, or by printing Chapter 67 of the San Francisco Administrative Code from the internet at: **www.ci.sf.ca.us/sunshine.htm**

To view Mental Health Board agendas and minutes, you may visit the MHB web page at: **www.ci.sf.ca.us/mental_health**. You may also go to the Government Information Center at the Main Library at Larkin and Grove in the Civic Center. You may also get copies of these documents through the MHB office at 255-3474.

Lobbyist Registration and Reporting Requirements

Individuals and entities that influence or attempt to influence local legislative or administrative action may be required by the San Francisco Lobbyist Ordinance [SF Campaign & Governmental Conduct Code 2.100] to register and report lobbying activity. For more information about the Lobbyist Ordinance, please contact the San Francisco Ethics Commission at 30 Van Ness Avenue, Suite 3900, San Francisco, CA 94102; telephone (415) 581-2300; fax (415) 581-2317; web site www.sfgov.org/ethics.

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MENTAL HEALTH BOARD
ATTACHMENT A
March 13, 2002

CONSENT CALENDAR

All items on the Consent Calendar are handled through a single vote. There will be no discussion unless a member requests it, in which case the item will be removed from Consent Calendar and discussed. Additional names may be added to the leave of absence resolution during the meeting.

1.2.a **PROPOSED RESOLUTION: Be it resolved that the minutes of the Mental Health Board meeting of January 9, 2002, be approved as submitted.**

1.2.b **PROPOSED RESOLUTION: Be it resolved that the Mental Health Board grants leaves of absence for the meeting of February 13, 2002, to the following members: Andrea Leung, Dr. Toye Moses.**

1.2.c **PROPOSED RESOLUTION: Be it resolved that the discussion notes of the Mental Health Board meeting of February 13, 2002, be approved as submitted.**

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MENTAL HEALTH BOARD
ATTACHMENT B
March 13, 2002

Added language is in italics.

PROPOSED RESOLUTION (MHB-2002-xx): RESPONDING TO THE BUDGET CRISIS WITH A COMPREHENSIVE REVENUE STRATEGY

WHEREAS, in the wake of the tragic events of September 11, 2001, local, state, and national economies have taken a downturn; and

WHEREAS, the City and County of San Francisco is facing a decline in revenue which in turn is threatening a potential 10% cut in services; and

WHEREAS, these cuts mean a crucial loss of services for individuals in the short-term; and

WHEREAS, these cuts will cause the City to lose experienced staff during a time when it is already very difficult to recruit qualified staff due to the cost of living in our City; and whereas staff who are laid off may be lost to our system permanently; and

WHEREAS, any treatment sites and service facilities which have to be closed down during the current crisis, may be impossible to re-establish in a future year depending on the real estate market; and,

WHEREAS, the users of the City's public health and human service systems are, in a sense, secondary victims of the attack of September 11th, and whereas the City itself is a secondary victim, in that its infrastructure of services is in being put in jeopardy, and

WHEREAS, with regard to mental health services, the Bronzan-McCorquodale Act of 1991 (Section 5600 and following in the State Welfare and Institutions Code) outlines a complete system of care as the most effective and cost-efficient way to provide services and mandates that Counties to the best of their ability provide a comprehensive system of services, and

WHEREAS, in San Francisco, Community Mental Health Services has spent years creating a strategic, cost-effective system of care with a focus on community-based treatment replacing institutional care, *which meets the Bronzan-McCorquodale guidelines*, and whereas, cuts will fragment that system and damage its cost effectiveness strategies, and

WHEREAS, a 10% cut will mean that many clients of the mental health system who go unserved will end up in very expensive institutional care—Psychiatric Emergency Services, inpatient units at San Francisco General Hospital, the county jail—or will end up homeless and out on the streets, with the possible ironic outcome that the cuts may cost the City more than they save, and

WHEREAS, the Mental Health Board further believes that a strong and effective public health system directly benefits all neighborhoods and economic sectors of the community; and

WHEREAS, the Mental Health Board believes that our community has a moral and ethical duty to care for those people who are ill, suffering, in trouble, and in need, now, therefore,

BE IT RESOLVED, that the Mental Health Board urges the City and County of San Francisco to respond to this crisis with a comprehensive revenue strategy, not just a cutting strategy, and to do a thorough and comprehensive review of all the City's revenue sources, on an emergency basis, to make sure that all property assessments, utility fees, cable fees, and other revenues are being collected fairly and completely, that loopholes are closed, that any under-assessments are brought into line with true market value, and that fees which have been historically low are brought up to date; and

BE IT FURTHER RESOLVED, that the Mental Health Board recommends that the City and County of San Francisco do everything in its power to protect the long-term investment it has made in its services, so permanent damage is not done, and to take all necessary steps to preserve and defend the vital, state-of-the art services the city has developed through years of intensive effort, and

BE IT FURTHER RESOLVED, that the Mental Health Board recommends that the City and County of San Francisco, realizing that San Francisco is still one of the wealthiest cities in the world, *realizing that the strength of our country comes first and foremost from the health, well-being and strength of its people and from the strength of its infrastructure*, and realizing that these are extraordinary times requiring extraordinary solutions, be assertive about instituting fair and progressive revenue increases, and

BE IT FURTHER RESOLVED, that the Mental Health Board recommends that the City and County of San Francisco, through such a revenue strategy, do everything in its power to fund the base line budget of the Department of Public Health with the inclusion of a COLA for the contractors, and to prevent the threatened 10% reduction, and

BE IT FURTHER RESOLVED, that the Mental Health Board recommends that the City and County of San Francisco continue to lobby strongly for parity in mental health care so that the public mental health system is not having to take clients who should rightly be covered by private insurance companies, and continue to lobby for health coverage for all citizens, thereby lessening the burden on municipal public health systems due to the numbers of uninsured or underinsured citizens, and

BE IT FURTHER RESOLVED, that the Mental Health Board urges the City and County of San Francisco to lobby strongly at the national level for tax policies which create a vigorous economy by focusing any financial stimulus on the middle class, the working class, and the poor, rather than further promoting a concentration of wealth in fewer and fewer hands.

SAN FRANCISCO MENTAL HEALTH BOARD

SEAL OF THE CITY AND COUNTY OF SAN FRANCISCO

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MENTAL HEALTH BOARD
ATTACHMENT C
March 13, 2002

PROPOSED RESOLUTION (MHB 2002-xx) REGARDING AB 1421, MENTAL HEALTH: INVOLUNTARY TREATMENT

WHEREAS, many people with severe psychiatric disabilities are unable or unwilling to access or receive mental health services, with disastrous results for the individual, their family and the community; and

WHEREAS, the Lanterman-Petris-Short Act, a California law enacted in 1967, already provides for involuntary in-patient treatment for those people whose mental disabilities make them "gravely disabled" or " a danger to self or others;" and

WHEREAS, the hearing, "Mandatory Mental Health Treatment: For Good or For Ill?" was held October 12, 2001 and public testimony was overwhelming against Involuntary Treatment and AB 1421; and

WHEREAS, in 1999 and 2000, over 300 homeless people in San Francisco were surveyed by the Coalition on Homelessness and over 92% said that if mental health programs were available that met their needs, they would willingly utilize services; and about one third said that they had attempted to access services and were unsuccessful; and

WHEREAS, the Little Hoover Commission report "Being There: Making a Commitment to Mental Health," Executive Summary, November, 2000 found:

"California's involuntary commitment law—the LPS Act—is one of the most controversial mental health issues of the day; however, the Commission found the most important and immediate concern to be the 1.5 million Californians who need help but do not receive it;" and

WHEREAS, as we have not been able to afford mental health care for many of our citizens who ask for it, we should not go looking for people at some added expense on which to force care that they do not want; and

WHEREAS, the Duke Study, in North Carolina, found that in order to effectively treat people with severe psychiatric disabilities a minimum of 36 treatment contacts a year were necessary; and whereas in California, people with severe psychiatric disabilities receive an average of three treatment encounters a year; and

WHEREAS, the MacArthur Treatment Competence Study found, "Most patients hospitalized with serious mental illness have abilities similar to persons without mental illness for making treatment decisions. Taken by itself, mental illness does not invariably impair decision making capacities; **On the other hand, a substantial percentage of hospitalized patients--up to half in the group with schizophrenia when all four types of abilities are considered--show high levels of impairment";**
and

WHEREAS, the MacArthur Violence Risk Assessment Study found that "the prevalence of violence among people who have been discharged from a hospital and who do not have symptoms of substance abuse is about the same as the prevalence among other people living in their communities who do not have symptoms of substance abuse;" and

WHEREAS, the Well Being Project, a research project supported by the California Department of Mental Health, found that 55% of clients interviewed who had experienced forced treatment reported that fear of forces treatment caused them to avoid all treatment for psychological and emotional problems; and

WHEREAS, people with psychiatric disabilities testified that involuntary mental health treatment undermines the development of a trusting, therapeutic relationship between the client, the mental health practitioner and their family; and

WHEREAS, people with psychiatric disabilities also testified that psychotropic medications, while they can be helpful in controlling symptoms, can also have very serious side effects; and should only be administered after informed consent; and

WHEREAS, the RAND study, "The Effectiveness of Involuntary Outpatient Treatment: Empirical Evidence and the Experience of Eight States," found that ~~these findings cannot be generalized to suggest that involuntary outpatient treatment would be more effective than alternative, non-coercive interventions for all target populations;"~~**"the research on court-ordered mental health treatment suggests that the two most salient factors in reducing recidivism and problematic behavior among people with severe mental illness appear to be enhanced services and enhanced monitoring.... While there may exist a subgroup of people with severe mental illness for whom a court order acts as leverage to enhance treatment compliance, the best studies suggest that the effectiveness of outpatient commitment is linked to the provision of intensive services. Whether court orders have any effect at all in the absence of intensive treatment is an unanswered question;"**
and

WHEREAS, AB 1421, a bill that would provide funding for Assisted Outpatient Treatment (involuntary treatment) is intended to serve a small number of people with severe psychiatric disabilities but defines the eligibility criteria for this treatment so broadly that many people with psychiatric disabilities could be inappropriately involuntarily treated; and

WHEREAS, the laws governing the commitment procedure in AB 1421 is so vague as to allow that the petition may be heard without its subject being present if "appropriate attempts to elicit the attendance of the person have failed;" and

WHEREAS, of the stakeholders the RAND study interviewed who supported involuntary outpatient treatment, there was significant "skepticism and uncertainty about the practical application of these laws;" and whereas the RAND study found that involuntary outpatient treatment is used infrequently in states where there are laws permitting it; and

WHEREAS, the RAND Institute study on the "Effectiveness of Involuntary Outpatient Treatment" found "clear evidence that alternative, community-based mental health treatments can produce good outcomes for people with severe mental illness;" and

WHEREAS, the landmark report "Mental Health: A Report of the Surgeon General," January, 2000, states, "One point is clear: the need for coercion should be reduced significantly when adequate services are readily accessible to individuals with severe mental disorders who pose a treat of danger to themselves or others;"and

WHEREAS, Involuntary Outpatient Treatment will subject many to the judicial system and will make those who steadfastly refuse to accept ordered treatment in contempt of court, thus establishing a new class of criminal; and whereas refusal of mental health treatment should not be treated as a crime any more that refusal of other health treatment; and

WHEREAS, the voluntary, comprehensive community-based programs resulting from State bills AB 34, AB 334, and AB 2034 provide the necessary outpatient treatment for individuals previously difficult to engage such as those who are homeless and exiting the jail system; and

WHEREAS. programs created in response to AB 2034 have been very effective in reducing hospital stays and jail time by providing intensive voluntary outpatient case management and support for individuals; and

WHEREAS. AB 1424, which became effective January 1, 2002, allows the medical history of a person to be considered in determining whether someone is gravely disabled or a danger to themselves or others, and whereas inclusion of this information at the certification hearings is expected to significantly impact decisions regarding involuntary inpatient commitment; and

WHEREAS, the National Council on Disability, an independent federal agency mandated to make recommendations to the President and Congress, extensively interviewed people with psychiatric disabilities and has recommended that:

"Laws that allow the use of involuntary treatments such as forced drugging and inpatient and outpatient commitment should be viewed as inherently suspect, because they are incompatible with the principle of self-determination. Public policy needs to move in the direction of a totally voluntary community-based mental health system that safeguards human dignity and respects individual autonomy" (Core Recommendation #1); and

WHEREAS, much of this resolution has been adopted from a resolution passed by the Mayor's Disability Council in San Francisco in November 2000; now, therefore

BE IT RESOLVED THAT, the San Francisco Mental Health Board urges the Mayor and the Board of Supervisors to support increased mental health funding for voluntary, community-based services and that the Mental Health Board specifically urges that the City and County of San Francisco take a position of opposition with regard to AB 1421 (Thomson); and

BE IT FURTHER RESOLVED THAT, the San Francisco Mental Health Board urges Community Mental Health Services in San Francisco, as well as the State of California, to develop ways of responding to the concerns of family members, such as by increasing mobile crisis services, by having support groups for family members as needed, and by case managers being open to hearing from family members as appropriate, and

BE IT FURTHER RESOLVED THAT, the San Francisco Mental Health Board urges the Mayor and the Board of Supervisors to provide funding for mobile crisis services in San Francisco 24 hours a day, seven days a week.

SAN FRANCISCO MENTAL HEALTH BOARD

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UNADOPTED MINUTES
Mental Health Board

Wednesday, March 13, 2002
1380 Howard Street, Room 537
San Francisco, CA 94103
6:30 p.m.

BOARD MEMBERS PRESENT: Ted Stinson (Chair); Robyn Buckins; Bob Douglas; Augusta Del Zotto; Carol Knight; Andrea Leung, L.C.S.W., A.C.S.W.; Toye Moses, Ph.D., M.P.H.; Kate Walker; Idell Wilson; Sandy Yuen.

BOARD MEMBERS ON LEAVE: Bridgett Brown; Alex Kitzes, Ph.D.; Rose Chung for Supervisor Aaron Peskin; Dennis Yun.

BOARD MEMBERS ABSENT: none.

PRESENTER:
Sandy Sohcot, Executive Director, Rex Foundation and Founder of the Women's Leadership Alliance, an advocacy organization.

OTHERS PRESENT: Linda Wang (CMHS Director of Adult Services); John Dorsey; April Chartrand (former MHB Member); Cathy Slack (Community Focus); Geneva Davis; Michael Wise (Voices at Bay Newsletter); Anjie Diaz (Artist, Student); Julia Diaz (Spiritmenders); Dorothy Shaffer (Parent); Tiffeny Jimenez (Student; worker); Madagan Shive (Mental Health Association); Helynna Brooke (MHB Executive Director); Rich Snowdon (MHB Administrator)

1.0 CALL TO ORDER AND CONSENT CALENDAR

1.1 Call to Order and Announcements from the Chair

The meeting was called to order at 6:49 p.m by Ted Stinson, Chair.

Mr. Stinson: Jo Ruffin, Director of Community Mental Health Services, will not be joining us this evening because she took a fall, and broke her wrist and dislocated her hip. Linda Wang, Director of Adult Services, is here in her place tonight.

We are very happy to be welcoming five new Board members tonight:

Sandy Yuen, appointed to a Public Interest Seat by Supervisor Aaron Peskin.

Idell Wilson, appointed to a Consumer Seat by Supervisor Sophie Maxwell and referred to the Board by Roma Guy, Vice President of the Health Commission.

Augusta Del Zotto, Ph.D., appointed to a Consumer Seat by Supervisor Gerardo Sandoval.

Robyn Buckins, appointed to a Family Member Seat by Supervisor Gavin Newsom.

Toye Moses, Ph.D., M.P.H., appointed to a Mental Health Professional Seat by Supervisor Tom Ammiano.

The new members then introduced themselves briefly:

Dr. Moses: I was a member of the Board through January 2001, and had to leave due to term limits, so I'm familiar with mental health policy and I'm glad to be back. I'm the Executive Director for the Southeast Facilities Commission in Bayview Hunters Point.

Ms. Yuen: I'm the Program Director of the National Youth Leadership Forum on Medicine. I have a deep interest in and commitment to mental health issues. I was the director of the Suicide Prevention Crisis Line for 5-6 years.

Ms. Wilson: I'm a student and a mother, and wear lots of other hats. I'm glad to be on this Board.

Dr. Del Zotto: I was a client of the system for a number of years. I work with the Center for Human Development, which contracts with the San Francisco School District. I'm very happy to be here.

Ms. Buckins: I'm a 40-year-old mother of four, and a legal assistant at Equal Rights Advocates. Mental illness has always been in my family. I feel very strongly about the mentally ill.

The rest of the Board members then introduced themselves.

1.2 Election of Officers

Mr. Stinson called for the election of officers to two-year terms beginning February 2002. The slate put forward by the Nominating Committee was announced. No nominations were received from the floor.

Chair: Ted Stinson
By unanimous vote

Vice Chair: Andrea Leung
By unanimous vote

Secretary: Toye Moses
By unanimous vote

1.3 Consent Calendar (Attachment A)

1.3.a RESOLUTION (MHB-2002-07): Be it resolved that the minutes of the Mental Health Board meeting of January 9, 2002, be approved as submitted. (Passed unanimously.)

1.3.b RESOLUTION (MHB-2002-08): Be it resolved that the Mental Health Board grants leaves of absence for the meeting of February 13, 2002, to the following members: Andrea Leung, and Dr. Toye Moses. (Passed unanimously.)

1.3.c RESOLUTION (MHB-2002-09): Be it resolved that the discussion notes of the Mental Health Board meeting of February 13, 2002, be approved as submitted. (Passed unanimously.)

1.3.d RESOLUTION (MHB-2002-10): Be it resolved that the Mental Health Board grants leaves of absence for the meeting of March 13, 2002, to the following members: Bridgett Brown, Dr. Alex Kitzes, and Dennis Yun. (Passed unanimously.)

2.0 DIRECTORS REPORTS

2.1 Report from the Director of Community Mental Health Services

Linda Wang, Director of Adult Services, reported for Jo Ruffin: What I'd like to do tonight is focus on the budget, which is one of the more pressing issues we're concerned about. The Department of Public Health was asked to submit a baseline budget to the Mayor and a budget with a 10% reduction. For CMHS the 10% reduction would mean a cut of over $7 million. Because we are an entity which takes care of a lot of Medi-Cal clients, actually our services are funded not only by the local tax dollars, but also by federal Medi-Cal dollars. What this means is that if we are in a position of having to reduce our services by 10% we would lose about $4 million of federal revenues.

Suppose a Medi-Cal client needs to go to SFGH, and the hospital day costs $500. If the person is on Medi-Cal, half of that is paid through federal dollars. So in having to cut local tax dollars, we're not able to provide the service, so we then lose the federal dollars. The impact of cutting General Fund dollars is much larger than just those dollars.

The Health Commission has passed the Department's reduction budget and sent it on to the Mayor's office. But the Health Commission also passed a resolution saying that they do not support making these cuts.

What we're waiting for is to find out if those cuts are taken or if some portion of those cuts are taken what they might be. We understand the Mayor's Office is planning to send a preliminary budget in April to the Board of Supervisors. The Mayor will continue working on it. It will not be his final submission. This is something the Board of Supervisors has asked for.

On a separate topic, the Director of Public Health asked us to undertake the Patient Flow Project, along with the SFGH Department of Psychiatry and residential providers. The Project is studying the ability of patients to move from one service to another service when they are ready. Sometimes that happens, but often we can't find a resource to meet their needs and they have to stay where they are.

The Patient Flow Project is focused on the inpatient beds at SFGH. The hope is that the patients who are no longer acute could move much more quickly to a lower level of care. This is really important, because when clients are in the hospital and don't need to be there, they get restless, they get upset, and lose the progress they've made.

And meanwhile we need their bed for someone in a more acute situation. We're hoping this Project will help us make better use of our resources. We hope we can make some organizational changes that will mean better patient care. And we hope this will help us continue to move resources from institutional care, to community based services. This is a major effort to adjust the system.

Dr. Moses: I'm very concerned about this 10% cut. Will that include providers which are community-based organizations, too? Ms. Wang: Yes. We've developed a plan which focuses on reducing inpatient and long-term care, reducing day treatment, reducing transitional residential treatment, and reducing outpatient care.

Dr. Moses: Do we have Plan A and Plan B, depending on what the Mayor says? Ms. Wang: We presented our plan in clusters of $2 million, in order to be ready for whatever the final budget is.

Mr. Douglas: Is anything happening to the proposal for the new 24-hour drop in center? Ms. Wang: The Department has done the planning for that center in coordination with homeless providers. But while the planning is done, there is no funding for implementation. Because we are being asked to cut our services, we could not fund it. But there are people who are still advocating for it.

Mr. Douglas: I was wondering if it would make sense to try for foundation money for this. But often foundations look for projects that they don't have to fund on a continuing basis.

Dr. Del Zotto: I've done a lot of fundraising. Unfortunately mental health has become less and less of a priority. It's very difficult to find money for mental health services.

Dr. Moses: I can make a suggestion. As you know part of the policy of this Board is to advocate for consumers. This budget process is not over yet. With Sophie Maxwell as Chair of the Budget Committee, they are going out to different communities to have hearings. I think it's important to have people at each of these hearings.

Dr. Del Zotto: It's important to show the City that foundations and corporations will not pick up the slack.

The Director's written report was distributed:

Budget Update. The Health Commission approved the Department's FY02-03 proposed budget which was forwarded to the Mayor's Office on February 22nd. In addition to the proposed budget, the Department presented a 10 percent General Fund reduction plan required by the Mayor's Office for use in the event the budget can't be balanced City-Wide. These reductions pose a significant impact to Community Mental Health Services, which prepared a plan equal to approximately $11 million in reductions, including both General Fund and matching revenues. The reductions were spread across most treatment modalities and would impact both civil service and contracted programs. The Department is anticipating more information regarding the use of this plan in late April once the Mayor's Office has the opportunity to analyze all of the departmental budget submissions.

Project Impact. The Project Impact staff, who previously worked out of offices at the Youth Guidance Center, were going to be homeless because the Juvenile Probation Department needed to re-claim its space. Last month the staff was successfully re-located to Child Crisis space at Bayview Plaza.

Southeast Child and Family Therapy Center Site. The Southeast Child and Family Therapy Center submitted a proposal to Rebuilding Together (formerly Christmas in April) to have some redecorating done at its Bennington Street site which houses an infant-parent group program. The proposal was accepted, and work is expected to be done by the end of April.

Infant-Parent Program and Child Trauma Research Project. The Infant-Parent Program and the Child Trauma Research Project are using funds that come to CYF from the state Proposition 10 money to train CYF clinicians in (a) infant-parent psychotherapy, and (b) dyadic treatment of parents and children exposed to domestic violence.

Patient Flow Exercise. In FY 00-01, an average of 18 beds at SFGH and the FFS hospitals were occupied by patients who no longer met the criteria for acute days. Two important issues follow from this situation. First and foremost, it means that there are people in the hospital who no longer need to be there, and who are probably not benefiting from additional hospitalization. Many of these patients are waiting for lower levels of care, e.g. residential treatment or long term care. They can't move to those lower levels of care because everything is jammed or because they have some special need, e.g. They can't take stairs, or they're insulin dependent diabetics who can't manage their own care- there are a myriad of such reasons.

Secondly, keeping patients who are not psychiatrically acute in the hospital creates a revenue problem because the hospital can only bill for a much lower administrative rate. The administrative day rate just doesn't cover the cost of keeping someone in the hospital. In a sense the administrative days are depriving hospitals of revenue they need to keep even with the cost of doing business.

Dr. Katz wants to see if a coordinated effort could result in a dramatic reduction in administrative days at the Department of Psychiatry at SFGH. He has asked all the parties involved in helping discharge patients to get together and to draw up a plan for a "patient flow exercise" to begin May 1, and to continue until June 30. The goal of the exercise will be to reduce administrative days at SFGH to as close to "0" as possible. Liz Gray, CMHS Director of Long Term Care, has been asked to coordinate this exercise. Liz has already begun meetings with care providers to brainstorm pathways to quick discharge. Another committee is co-chaired by Gene O'Connell and Barbara Garcia. This committee is looking at policies that impede patient flow. It is already apparent that some efficiency may be realized by having staff from a variety of settings work together more collaboratively. Additionally, resources for lower levels of care will be expanded through the purchase of "patch" beds.

This is a very exciting exercise and we will keep the MHB informed of the process.

2.2 Report from the Executive Director of the Mental Health Board

Ms. Brooke: I've been working very hard on recruiting new members. We've got some really, really great people. Other names have been submitted to other Supervisors to fill vacancies we still have on the Board.

Mr. Stinson: I'd like to praise Helynna for her work in getting Board members, and especially so we could have a quorum tonight.

3.0 PRESENTATION: ADVOCACY WORKSHOP

Mr. Stinson: In talking about the presentation for tonight, the Executive Committee felt an urgency to take action right now on the budget crisis. One of our three goals for this year is advocacy, and we're hoping to learn more about that tonight.

Sandy Sohcot is the Executive Director of the Rex Foundation, which was founded by the Grateful Dead, and she's the Founder of the Women's Leadership Alliance.

Ms. Sohcot: I'm glad to be here. I'd like to share some of the wisdom that I've picked up over the years, but I want to do more of a discussion about what you want to present and what your concerns are.

One of my first advocacy jobs was organizing for the White House Conference on Small Business. There were 1600 delegates who voted on recommendations requesting legislation to make it easier to make small loans. My particular recommendation was to change banking regulations, reducing requirements so as to make those loans easier, and this was successful.

What I learned in that work, is that what's really important when you go before people is first to give context: What's the current situation. What's currently happening. What has our current level of expenditures supported. What benefits are we bringing to the city. You want to make it very easy for the people listening to you to understand what the situation is, what you're proposing, and what you're asking them to do.

The three steps of advocacy are: 1) Here's where we are, 2) here's what we're proposing and why, and 3) here's what we're asking of you. So it's very clear what you want of the people listening to you.

When you're stating what you're proposing, you want to make a case for how your proposal is helping the people listening to you to do their job well. That's what's in it for them. You're helping them do an effective job. You're going to show them an overall saving of cost. You're going to minimize the loss of revenue. You're going to help them look at the bigger picture rather than just focusing on the 10% cut. And that will help them be more effective.

If you have the opportunity to build rapport and meet with Supervisors before going to the Board as a whole that can make a big difference, because then you are seen not just as asking for something, but you are seen as people who have a connection with them.

You can cite things they've done in the past that you appreciate, so they know you're paying attention to what they're doing.

Dr. Moses: Do you suggest to do that individually or collectively?

Ms. Sohcot: It can be helpful for small groups to go together. It's helpful to have a sense of a team, but we're not bombarding them. It's really important to establish rapport in the beginning, telling them what you appreciate them for.

You want to listen to them first and find out what their concerns are. This gives you a chance to get a better idea of what they might be thinking, and then you can address that in your presentation.

Mr. Stinson: What are your thoughts on tone and how to structure your message. We feel passionate about these issues. Sometimes you feel like saying it in a loud voice because you don't feel like people are hearing you. How do you approach a Supervisor who has a lot of issues they're dealing with?

Ms. Sohcot: What I have found is the more reasonable your tone the more effective you'll be. If you are too passionate the person can start to feel defensive. You want to engage someone to really listen to what you have to say. If you are in a small meeting, you have a chance to show some empathy for the Supervisors that they are in a tough position with hard decisions to make that will make a lot of people unhappy.

It's good to be clear and firm, but not to the point where it could turn somebody off.

Mr. Douglas: I think it would be very helpful to have a cheat sheet with the issues laid out, something I could memorize as a guide. Mr. Stinson: That might be good for focusing on tonight. Ms. Sohcot: Let's start with what are the one or two main points.

Mr. Douglas: I think we can give them credit for creating this wonderful system and then talk with them about keeping it going.

Ms. Sohcot: What are the key areas you want to highlight in terms of what your budget covers?

Ms. Walker: I think the main point is the one Ted talked about. It's short sighted not to take care of people. For instance the Mobile Crisis Unit, you can do away with it and save money. But the people who could have been helped easily, will be much more expensive to help in the end.

Mr. Stinson: I think most people would agree, there are not enough services to begin with, let alone if you contemplate taking 10% of the cut away. Dr. Del Zotto: That logic could backfire. If you're in bad shape now, what's the loss of a few more million? It could go either way.

Mr. Stinson: We could start by talking about some of the positive things we've done in the past year, such as the Police Crisis Intervention Training, which is generally recognized as a large success.

Ms. Wang: CMHS is serving 16,000-20,000 people per year now. Mr. Stinson: What is the unmet need in our community? Ms. Wang: If you look at the homeless population, the general feeling is that 30% are mentally ill and about 60% are using substances, and that population we are barely able to touch.

Ms. Leung: Sometimes for an extended period they have a hotel, and so they are not considered homeless. I think there might be another 20-40% who are in a transitional state.

Ms. Buckins: We have these homeless trying to find hotel rooms which are in the Tenderloin, and they don't have the income to pay for places where they can go. There are transitional homes. It costs $600-700 per month to stay there. Where do they go from there? You can't live in San Francisco for $800 per month. I don't see a long-term solution for mentally ill people to be able to support themselves and get out of being homeless.

Mr. Stinson: Perhaps we should start with something positive, like PCIT or Mobile Crisis. What are you and the Department the most proud of over the last year? The picture we want to paint is here is a very competent City department.

Ms. Wang: I think the fact that we serve so many people with the budget we're given is pretty impressive. In this past year, we were actually able to reduce the number of hospital days that we needed to use, which means that our community programs were doing a good job. Dr. Del Zotto: Those days were cut in response to effective treatment.

Mr. Douglas: There was a great response to 9-11. Dr. Moses: We also provide services to mentally ill people who are incarcerated. That's another important area.

Ms. Sohcot: The next step is to show them if the proposed cut occurs, then what would happen to these services.

Ms. Wang: We can work on projecting the numbers. But the cuts will reduce our alternatives to hospitalization. So we run a higher risk that people who can't get community care will go back to institutional care. Mr. Stinson: Let's get them focused on the specific number we're going to be talking with them.

Ms. Sohcot: And the third step is, what are you asking them to do.

Mr. Stinson: We're asking that the cut not be made. That we stay at the current level.

Ms. Walker: We're asking to not make these cuts, because in the long run, the City's expenses will be higher if you do.

Ms. Wang: What the Health Commission did was to create a base budget and a 10% reduction budget. The base budget is what the department needs just to keep things as is. In that are the added costs for increased salaries. There is an additional need for 1-2 Napa beds. And the costs are going to be more next year than this year. The difference was made up by bringing in more Medi-Cal revenues.

But what the Health Commission did when it reviewed the base budget was it said this is not enough. We need to build in a 5% COLA for the contractors, the nonprofit providers. Also the add backs the Supervisors traditionally make should be built in to the base budget.

Ms. Sohcot: Why does this make sense? Why should the supervisors support your proposal?

Ms. Walker: If you do cut as you propose, you're going to be spending more money. The reason you will be spending more money is because you are denying help to people when they are most easily and least expensively able to be helped. You are pushing them, cruelly, into a deeper sickness.

For instance, we need another Mobile Crisis Unit. The cost for the people is x amount, the cost for the car is x, along with office and incidentals. You can cut that easily. You can see that. And what you will do is cruel to the people who need help when they are on the verge of going out of control. You are refusing them help. You are being more expensive. If that person goes out of control, you have to call the police. A police officer's salary is so much per hour, plus the car, and what will they do?

There will be incidents like police officer x who picked up a person who was a danger t0 the people around him. The officer tooks that person to SFGH. But SFGH had no room for them. And the police officer had to stay with the person till a place is found. That's x number of hours. So when you refuse another Mobile Crisis unit. If you add up all the costs in this incident, the City has to pay x amount of money instead of x amount of money.

Ms. Sohcot: So you're saying that people are going to still need services, but now the services will cost more. Dr. Del Zotto: If you add in child protection services, they are really costly. Ms. Buckins: It definitely will be more of a cost to SFGH.

Ms. Brooke: In our individual meetings with the Supervisors, we have more time, but before the full Board and the Health Commission, we have only 3 minutes. So we have to be able to put our message across quickly.

Mr. Stinson: We need a single number. A cut of x million, will cost x million. We can base it on assumptions, as long as they are grounded in experience and reasonableness.

Mr. Douglas: There might be a increase at the VA hospital. There will be an impact on people losing jobs. Mr. Stinson: Reduced employment will have an impact on the system.

Ms. Sohcot: With certain cuts, you may not be able to replace the lost services. Ms. Wang: It takes time to build services. It takes time to build expertise and staff. Ms. Walker: And you can lose properties. Mr. Stinson: The infrastructure takes a lot of time to build and you can knock it down overnight.

Ms. Brooke: There are three kinds of opportunities for us. I can make appointments for meetings with the individual supervisors and we can get 15 to 30 minutes. The other opportunities are the Town Hall meetings the Supervisors will be having in their districts. It would be good to have Board members at those. The third opportunity is that the Budget committee will be having a hearing on the Department of Public Health in a few weeks. Then there will be ongoing opportunities in front of the Budget Committee.

Ms. Sohcot I think it would be good if you had a fairly succinct document, hopefully not more than 2 pages, showing the current situation, with the cost and numbers, and what happens if you cut, with the cost and numbers. Also try to get an understanding of what the supervisors concerns are. If you can learn what they're thinking, then you can answer their objections.

Mr. Stinson to Ms. Sohcot: This has been very valuable. Thank you.

4.0 MENTAL HEALTH BOARD COMMITTEES

4.1 Report of the Chair of the Board and Executive Committee

Mr. Stinson: We've historically had the following committees: Program and Services, Children's Committee, and Cultural Competency and Special Populations. Those committees do work around issues specific to their topic areas. In thinking about where we are today, with so many new Board members, we are thinking to have the Board review the committee structure after all our new members are appointed, and either keep the same structure or create something new. We will probably try to do that sometime in the next several months.

In the interim we have come up with something we think is timely. Consistent with what we've been talking about tonight, the Executive Committee is reviewing the idea of forming two committees to respond to budget issues and to operate until July:

1. The current Cultural Competency and Special Populations Committee, chaired by Andrea, would be responsible for developing a media strategy and reaching minority communities around mental health issues, including the budget crisis.

2. Another committee would think about the strategies around the budget and how we want to respond, much like we're doing tonight. It would work on the analysis and numbers.

Both of these committees would work together. We would even likely meet on the same night, the third Wednesday of the month. Both staff would be here. This would mean that the committees could communicate very easily with each other.

This is something the Executive Committee is reviewing and we hope to come back to you at the next meeting with a decision.

4.1.a RESOLUTION (MHB-2002-11): RESPONDING TO THE BUDGET CRISIS WITH A COMPREHENSIVE REVENUE STRATEGY

WHEREAS, in the wake of the tragic events of September 11, 2001, local, state, and national economies have taken a downturn; and

WHEREAS, the City and County of San Francisco is facing a decline in revenue which in turn is threatening a potential 10% cut in services; and

WHEREAS, these cuts mean a crucial loss of services for individuals in the short-term; and

WHEREAS, these cuts will cause the City to lose experienced staff during a time when it is already very difficult to recruit qualified staff due to the cost of living in our City; and whereas staff who are laid off may be lost to our system permanently; and

WHEREAS, any treatment sites and service facilities which have to be closed down during the current crisis, may be impossible to re-establish in a future year depending on the real estate market; and,

WHEREAS, the users of the City's public health and human service systems are, in a sense, secondary victims of the attack of September 11th, and whereas the City itself is a secondary victim, in that its infrastructure of services is in being put in jeopardy, and

WHEREAS, with regard to mental health services, the Bronzan-McCorquodale Act of 1991 (Section 5600 and following in the State Welfare and Institutions Code) outlines a complete system of care as the most effective and cost-efficient way to provide services and mandates that Counties to the best of their ability provide a comprehensive system of services, and

WHEREAS, in San Francisco, Community Mental Health Services has spent years creating a strategic, cost-effective system of care with a focus on community-based treatment replacing institutional care, which meets the Bronzan-McCorquodale guidelines, and whereas, cuts will fragment that system and damage its cost effectiveness strategies, and

WHEREAS, a 10% cut will mean that many clients of the mental health system who go unserved will end up in very expensive institutional care—Psychiatric Emergency Services, inpatient units at San Francisco General Hospital, the county

jail—or will end up homeless and out on the streets, with the possible ironic outcome that the cuts may cost the City more than they save, and

WHEREAS, the Mental Health Board further believes that a strong and effective public health system directly benefits all neighborhoods and economic sectors of the community; and

WHEREAS, the Mental Health Board believes that our community has a moral and ethical duty to care for those people who are ill, suffering, in trouble, and in need, now, therefore,

BE IT RESOLVED, that the Mental Health Board urges the City and County of San Francisco to respond to this crisis with a comprehensive revenue strategy, not just a cutting strategy, and to do a thorough and comprehensive review of all the City's revenue sources, on an emergency basis, to make sure that all property assessments, utility fees, cable fees, and other revenues are being collected fairly and completely, that loopholes are closed, that any under-assessments are brought into line with true market value, and that fees which have been historically low are brought up to date; and

BE IT FURTHER RESOLVED, that the Mental Health Board recommends that the City and County of San Francisco do everything in its power to protect the long-term investment it has made in its services, so permanent damage is not done, and to take all necessary steps to preserve and defend the vital, state-of-the art services the city has developed through years of intensive effort, and

BE IT FURTHER RESOLVED, that the Mental Health Board recommends that the City and County of San Francisco, realizing that San Francisco is still one of the wealthiest cities in the world, realizing that the strength of our country comes first and foremost from the health, well-being and strength of its people and from the strength of its infrastructure, and realizing that these are extraordinary times requiring extraordinary solutions, be assertive about instituting fair and progressive revenue increases, and

BE IT FURTHER RESOLVED, that the Mental Health Board recommends that the City and County of San Francisco, through such a revenue strategy, do everything in its power to fund the base line budget of the Department of Public Health with the inclusion of a COLA for the contractors, and to prevent the threatened 10% reduction, and

BE IT FURTHER RESOLVED, that the Mental Health Board recommends that the City and County of San Francisco continue to lobby strongly for parity in mental health care so that the public mental health system is not having to take clients who should rightly be covered by private insurance companies, and continue to lobby for health coverage for all citizens, thereby lessening the burden on municipal public health systems due to the numbers of uninsured or underinsured citizens, and

BE IT FURTHER RESOLVED, that the Mental Health Board urges the City and County of San Francisco to lobby strongly at the national level for tax policies which create a vigorous economy by focusing any financial stimulus on the middle class, the working class, and the poor, rather than further promoting a concentration of wealth in fewer and fewer hands. (Passed unanimously.)

4.2 Children's Committee

No report.

4.3 Cultural Competency and Special Populations Committee

Ms. Leung: We'd like to visit different sites to get to know the programs. At the same time we have a media approach so hopefully the Mental Health Board will be more recognized in the community.

4.4 Program and Services Committee

Mr. Stinson: This resolution has been on the agenda for a number of months now. I would like a show of hands, especially new members, of how many of you have had a chance to review this. There are passionate views on both sides of the issue.

Since so few people have been able to study this issue, I'd like to table this until the next meeting. I feel strongly that we as a Board need to understand this before we vote on it.

4.5 State Liaison

Mr. Stinson: Kate Walker is our State Liaison which means that she keeps her finger on the pulse of the bills in the State legislature.

Mr. Douglas: I attended the Homeless Summit and I was really impressed. I told them I was on the MHB and would like to be able to follow up with them. All the members of the Board of Supervisors were there. Just about everybody except the Mayor was there.

5.0 PUBLIC COMMENT

Mr. Wise: I'm the Editor of Voices at Bay, a consumer newsletter published by the San Francisco Network of Mental Health Clients. I had occasion to meet with Amelia Truman, of the Community Advisory Board of the Department of Psychiatry at San Francisco General Hospital. They have a clothing project for clients in the inpatient units. I you can donate clothing or money, they can really use it. They are recruiting new people for their Board, and they meet the second Tuesday of the month.

Ms. Shive: I'm a staff person at the Mental Health Association. I facilitate the Consumer Housing Group. One recent issue that has been brought to our group, is that for a while now there has been no consumer representation on the CMHS Bed Committee. Just as we have consumers on the Mental Health Board, we need them on the Bed Committee to be part of the process of planning for discharge as people are transitioning to the community. I know there was a time when there was a consumer on the Bed Committee and I hope we can have that again soon.

Ms. Wang: The Bed Committee is no longer a committee, but has become a staff function. The original Bed Committee was to authorize levels of care and in the beginning it met every weekday. There may be occasional problem solving meetings of the staff, but the Bed Committee no longer involves daily meetings.

Ms. Diaz: Consumer input to other consumers who are transitioning can be important so they get the appropriate treatment and appropriate housing, so they don't end up back in the hospital. It's important for peers to help each other.

Ms. Shive: As an advocate from the MHA, I wanted to say that the City budget not only affects the City system, but also a lot of the nonprofits in the city are vulnerable.

Ms. Davis: I'm an applicant for the MHB. In terms of the effects of the cuts, they put additional pressure on the nonprofits in the city to provide services. It's a common misconception that mental disease is a chronic side effect of substance abuse.

If this budget cut happens, we can petition to put something on the ballot, that San Franciscans can vote on. I work at the Haight Ashbury Neighborhood Center, and work on outreach with SF Community Clinics Consortium..

There being no further business, the meeting was adjourned at 8:35 p.m.

04-05-02 A11

SAN FRANCISCO MENTAL HEALTH BOARD

1380 Howard Street, Suite 510
San Francisco, CA 94103
(415) 255-3474 fax: 255-3760
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www.ci.sf.ca.us/mental_health

MEETING OF THE MENTAL HEALTH BOARD

Wednesday, April 10, 2002
1380 Howard, Room 537
6:30 p.m.

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AGENDA

Public comments will be taken for each agenda item.

1.0 CALL TO ORDER AND CONSENT CALENDAR (10 minutes)

For discussion and proposed action

1.1 Call to Order and Announcements from the Chair

1.2 Consent Calendar (Attachment A)

1.2.a PROPOSED ACTION: Be it resolved that the minutes of the Mental Health Board meeting of March 13, 2002, be approved as submitted.

1.2.b PROPOSED ACTION: Be it resolved that the Mental Health Board grants leaves of absence for the meeting of April 10, 2002, to the following members: Bridgett Brown

1.2.c PROPOSED ACTION: Resolution that the Mental Health Board commend Carol Patterson for her years in being a leader in the mental health consumer movement in San Francisco.

1.2.d. PROPOSED ACTION: To send a letter to the Board of Supervisors that the MHB is in full support of the resolution proposed by Supervisor Ammiano urging the San Francisco legislative delegation to introduce an amendment to the California Constitution declaring the rights of the mentally disabled to housing, health care, and food to be public concerns and affirmative obligations of the State.

2.0 PRESENTATION: The Impact of Proposed Budget Cuts on Residential and Acute Care Programs in the San Francisco mental health system (50 minutes)

Jonathan Vernick, Director, Baker Places, along with Richard Heasley, Director, Conard House and John Nickens, Ph.D., Progress Foundation ,will present their programs, who they serve, and how the proposed cuts would impact services to their residents.

3.0 DIRECTORS REPORTS (30 minutes)

For discussion

3.1 Report from the Director of Community Mental Health Services

A report on the activities and operations of Community Mental Health Services, including budget, planning, policy, and programs and services.

3.2 Report from the Executive Director of the Mental Health Board

A report including updates and announcements regarding the activities and operations of the Board.

4.0 MENTAL HEALTH BOARD COMMITTEES (20 minutes)

For discussion and proposed action

4.1 Report of the Chair of the Board and Executive Committee

The chair will report discussions and actions of Executive Committee. Committee chairs will describe the two Ad Hoc Committees and seek participants.

4.1.a PROPOSED ACTION: Resolution that the Mental Health Board urges the Mayor and the Board of Supervisors to oppose AB 1421, Mental Health, Involuntary Outpatient Treatment. (Attachment B)

4.2 State Liaison

A report on developments regarding mental health services, policy, and funding at the state level, including the California legislature, the State Department of Mental Health, and other statewide advocacy or policy organizations.

5.0 PUBLIC COMMENT (10 minutes)

This is an opportunity for members of the public to address the Mental Health Board on items of interest to the public that are within the subject matter jurisdiction of the Mental Health Board. Additionally, public comments will be taken for each agenda item.

This agenda and all attachments can be viewed at: www.ci.sf.ca.us/mental_health. Attachments are also available at the Mental Health Board Office, 1380 Howard Street, Suite 510, telephone 255-3474.

DISABILITY ACCESS

1. American Sign Language interpreters and/or a sound enhancement system will be available on request. Please contact Ladonnis Elston at (415) 255-3444 (voice) or (415) 255-3449 (TTD) 5 days before the meeting. Large print copies of the agenda will be made available upon request; please call (415) 255-3474.

2. Meetings are held at 1380 Howard Street (corner of 10th Street), in Room 537. The closest accessible BART station is the Civic Center station, at the intersection of Market, Grove and Hyde Streets. The closest Muni Metro station is the Van Ness Station. Accessible MUNI lines serving the location are the 9 San Bruno, 47 Van Ness, and the 72 Haight/Noriega. For more information or updates about the current status of MUNI accessible services, call (415) 923-6142. For information about Paratransit Services call (415) 351-7000.

3. The main entrance to 1380 Howard is accessible to wheelchairs. Elevators, doorways, restrooms, and the meeting room are wheelchair accessible. Accessible curbside parking has been designated on Grace Alley which runs on the opposite side of the building from 10th Street.

4. In order to assist the City's efforts to accommodate persons with severe allergies, environmental illnesses, multiple chemical sensitivity or related disabilities, attendees at public meetings are reminded that other attendees may be sensitive to various chemical based products. Please help the City accommodate these individuals.

POLICY ON CELL PHONE, PAGERS, AND ELECTRONIC DEVICES

The ringing of and use of cell phones, pagers, and similar sound-producing electronic devices are prohibited at this meeting. Please be advised that the Chair may order the removal from the meeting room of any person(s) responsible for the ringing or use of a cell phone, pager, or other similar sound-producing electronic devices.

KNOW YOUR RIGHTS UNDER THE SUNSHINE ORDINANCE

Government's duty is to serve the public, reaching its decisions in full view of the public. Commissions, boards, councils and other agencies of the City and County exist to conduct the people's business. This ordinance assures that deliberations are conducted before the people and that City operations are open to the people's review. For more information on your rights under the Sunshine Ordinance (Chapter 67 of the San Francisco Administrative Code) or to report a violation of the ordinance, contact:

Donna Hall
Sunshine Ordinance Task Force
City Hall, Room 244
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102-4689
Telephone: (415)554-7724
Fax: 4(15) 554-5163
E-mail: Donna_Hall@ci.sf.ca.us

Citizens interested in obtaining a free copy of the Sunshine Ordinance can request one from Ms. Hall, or by printing Chapter 67 of the San Francisco Administrative Code from the internet at: **www.ci.sf.ca.us/sunshine.htm**

To view Mental Health Board agendas and minutes, you may visit the MHB web page at: **www.ci.sf.ca.us/mental_health**. You may also go to the Government Information Center at the Main Library at Larkin and Grove in the Civic Center. You may also get copies of these documents through the MHB office at 255-3474.

Lobbyist Registration and Reporting Requirements
Individuals and entities that influence or attempt to influence local legislative or administrative action may be required by the San Francisco Lobbyist Ordinance [SF Campaign & Governmental Conduct Code 2.100] to register and report lobbying activity. For more information about the Lobbyist Ordinance, please contact the San Francisco Ethics Commission at 30 Van Ness Avenue, Suite 3900, San Francisco, CA 94102; telephone (415) 581-2300; fax (415) 581-2317; web site www.sfgov.org/ethics.

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MENTAL HEALTH BOARD
ATTACHMENT A
April 10, 2002

CONSENT CALENDAR

All items on the Consent Calendar are handled through a single vote. There will be no discussion unless a member requests it, in which case the item will be removed from Consent Calendar and discussed. Additional names may be added to the leave of absence resolution during the meeting.

1.2.a **PROPOSED RESOLUTION: Be it resolved that the minutes of the Mental Health Board meeting of March 13, 2002, be approved as submitted.**

1.2.b **PROPOSED RESOLUTION: Be it resolved that the Mental Health Board grants leaves of absence for the meeting of April 10, 2002, to the following members: Bridgett Brown.**

1.2.c **PROPOSED RESOLUTION: Be it resolved that the Mental Health Board present the following certificate of gratitude to Carol Patterson:**

The Mental Health Board of San Francisco presents this
Certificate of Gratitude to:

Carol Patterson
For the pioneering role you've played since 1986 in empowering
mental health clients in San Francisco.
For establishing and running the BUILD Project, providing services
and now peer-counseling for people with psychiatric disabilities.
For being a founding member and leader of the Consumer/Family Member Task Force
of the Mental Health Board.
For your dedicated work with the National Empowerment Center.
For your advocacy for consumer employment in the mental health system
through Jobs Now.
For being such an inspiration to so many consumer activists whom you've mentored.
We'll miss you and wish you the very best in your new position of leadership.

1.2.d **PROPOSED RESOLUTION:** Be it resolved that the Mental Health Board send a letter to the Board of Supervisors in full support of the resolution proposed by Supervisor Ammiano urging the San Francisco legislative delegation to introduce an amendment to the California Constitution declaring the rights of the mentally disabled to housing, health care, and food to be public concerns and affirmative obligations of the State.

Resolution urging the San Francisco legislative delegation to introduce an amendment to the California Constitution declaring the rights of the mentally disabled to housing, health care, and food to be public concerns and affirmative obligations of the State.

WHEREAS, California's mental health system is inadequate in its resources and design to ensure quality mental health carE to those who need it; and

WHEREAS, California spends billions of dollars addressing the consequences of untreated mental illness rather than spending that money more wisely on ensuring adequate mental health treatment; and,

WHEREAS, The Little Hoover Commission report of 2000 calculates that mental illness costs the California economy up to $10 billion annually in indirect costs, including losses in productivity; and,

WHEREAS, As a result of inadequate mental health resources, the criminal justice system has become a mental health service provider and a safety net in times of crisis for an increasing number of juveniles and adults who would be more properly served by a therapeutic and adequate mental health system; and

WHEREAS, There is in California a critical lack of mental health professionals, including an insufficient number of slots in academic programs to develop psychiatrists, social workers, and nurse practitioners; and,

WHEREAS, The overriding goal of mental health reform is ensuring that people who need care have access to high quality, tailored mental health services in their communities, in the least restrictive settings, designed to foster recovery, and that access to recovery is not barred by either societal discrimination or inadequate mental health treatment; and

WHEREAS, The text of the proposed amendment to the California Constitution is on file with the Clerk of the Board of Supervisors in File No. xx (see below), which is hereby declared to be a part of this resolution as if set forth fully herein; and now, therefore, be it

RESOLVED, That the San Francisco State legislative delegation be urged to introduce a bill proposing an amendment to the California Constitution to declare the rights of the mentally disabled to housing, health care, and food to be public concerns and affirmative state obligations; and, be it

FURTHER RESOLVED, That the lobbyists on behalf of the City and County of San Francisco be directed to garner support for such an amendment.

Proposed Amendment of Article I of the California Constitution Affirmative Obligations of the State toward the Mentally Disabled

Section 1. Preamble

California's mental health system is inadequate in its resources and design to ensure quality mental health car to those who need it. California spends billions of dollars addressing the consequences of untreated mental illness rather than spending that money on adequate service. California's counties have limited resources and cannot adequately meet their residents' mental health needs. Mental illness costs the California economy up to $10 billion annually in indirect costs. Direct costs for public and private and mental health care and substance abuse treatment in California are estimated to be $9.5 billion annually. The human cost of an inadequate mental health system is illustrated by the 1997 figure of 3,430 California suicides, the leading cause of preventable death.

The overriding goal of mental health reform is ensuring that individuals who need care have access to high quality, tailored mental health services in their communities, in the least restrictive settings, designed to foster recovery, and that access to recovery is not barred by societal discrimination, inadequate mental health treatment, or lack of housing and food.

Section 2. Section 32 is added to Article I of the California Constitution to read:

Sec. 32 (a) Persons with mental disabilities retain all the rights, privileges, opportunities, and responsibilities of other citizens, unless specifically limited by federal or state law or regulation.

(b) The housing, health care, and food needs of the mentally ill are public concerns and shall be provided by the State, in cooperation with its subdivisions, in such manner and by such means as the legislature may from time to time determine.

(c) The funding obligations for these needs shall be borne by the State. Funding for these needs shall not be subject to the appropriations limits set forth in Article XIIIIB of the California Constitution.

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MENTAL HEALTH BOARD
ATTACHMENT Q B
April 10, 2002

PROPOSED RESOLUTION (MHB 2002-xx) REGARDING AB 1421, MENTAL HEALTH: INVOLUNTARY TREATMENT

WHEREAS, many people with severe psychiatric disabilities are unable or unwilling to access or receive mental health services, with disastrous results for the individual, their family and the community; and

WHEREAS, the Lanterman-Petris-Short Act, a California law enacted in 1967, already provides for involuntary in-patient treatment for those people whose mental disabilities make them "gravely disabled" or " a danger to self or others;" and

WHEREAS, the hearing, "Mandatory Mental Health Treatment: For Good or For Ill?" was held October 12, 2001 and public testimony was overwhelming against Involuntary Treatment and AB 1421; and

WHEREAS, in 1999 and 2000, over 300 homeless people in San Francisco were surveyed by the Coalition on Homelessness and over 92% said that if mental health programs were available that met their needs, they would willingly utilize services; and about one third said that they had attempted to access services and were unsuccessful; and

WHEREAS, the Little Hoover Commission report "Being There: Making a Commitment to Mental Health," Executive Summary, November, 2000 found:

"California's involuntary commitment law—the LPS Act—is one of the most controversial mental health issues of the day; however, the Commission found the most important and immediate concern to be the 1.5 million Californians who need help but do not receive it;" and

WHEREAS, as we have not been able to afford mental health care for many of our citizens who ask for it, we should not go looking for people at some added expense on which to force care that they do not want; and

WHEREAS, the Duke Study, in North Carolina, found that in order to effectively treat people with severe psychiatric disabilities a minimum of 36 treatment contacts a year were necessary; and whereas in California, people with severe psychiatric disabilities receive an average of three treatment encounters a year; and

WHEREAS, the MacArthur Treatment Competence Study found, "Most patients hospitalized with serious mental illness have abilities similar to persons without mental illness for making treatment decisions. Taken by itself, mental illness does not invariably impair decision making capacities; **On the other hand, a substantial percentage of hospitalized patients--up to half in the group with schizophrenia when all four types of abilities are considered--show high levels of impairment";**
and

WHEREAS, the MacArthur Violence Risk Assessment Study found that "the prevalence of violence among people who have been discharged from a hospital and who do not have symptoms of substance abuse is about the same as the prevalence among other people living in their communities who do not have symptoms of substance abuse;" and

WHEREAS, the Well Being Project, a research project supported by the California Department of Mental Health, found that 55% of clients interviewed who had experienced forced treatment reported that fear of forces treatment caused them to avoid all treatment for psychological and emotional problems; and

WHEREAS, people with psychiatric disabilities testified that involuntary mental health treatment undermines the development of a trusting, therapeutic relationship between the client, the mental health practitioner and their family; and

WHEREAS, people with psychiatric disabilities also testified that psychotropic medications, while they can be helpful in controlling symptoms, can also have very serious side effects; and should only be administered after informed consent; and

WHEREAS, the RAND study, "The Effectiveness of Involuntary Outpatient Treatment: Empirical Evidence and the Experience of Eight States," found that ~~these findings cannot be generalized to suggest that involuntary outpatient treatment would be more effective than alternative, non-coercive interventions for all target populations;"~~**"the research on court-ordered mental health treatment suggests that the two most salient factors in reducing recidivism and problematic behavior among people with severe mental illness appear to be enhanced services and enhanced monitoring.... While there may exist a subgroup of people with severe mental illness for whom a court order acts as leverage to enhance treatment compliance, the best studies suggest that the effectiveness of outpatient commitment is linked to the provision of intensive services. Whether court orders have any effect at all in the absence of intensive treatment is an unanswered question;"**
and

WHEREAS, AB 1421, a bill that would provide funding for Assisted Outpatient Treatment (involuntary treatment) is intended to serve a small number of people with severe psychiatric disabilities but defines the eligibility criteria for this treatment so broadly that many people with psychiatric disabilities could be inappropriately involuntarily treated; and

WHEREAS, the laws governing the commitment procedure in AB 1421 is so vague as to allow that the petition may be heard without its subject being present if "appropriate attempts to elicit the attendance of the person have failed;" and

WHEREAS, of the stakeholders the RAND study interviewed who supported involuntary outpatient treatment, there was significant "skepticism and uncertainty about the practical application of these laws;" and whereas the RAND study found that involuntary outpatient treatment is used infrequently in states where there are laws permitting it; and

WHEREAS, the RAND Institute study on the "Effectiveness of Involuntary Outpatient Treatment" found "clear evidence that alternative, community-based mental health treatments can produce good outcomes for people with severe mental illness;" and

WHEREAS, the landmark report "Mental Health: A Report of the Surgeon General," January, 2000, states, "One point is clear: the need for coercion should be reduced significantly when adequate services are readily accessible to individuals with severe mental disorders who pose a treat of danger to themselves or others;"and

WHEREAS, Involuntary Outpatient Treatment will subject many to the judicial system and will make those who steadfastly refuse to accept ordered treatment in contempt of court, thus establishing a new class of criminal; and whereas refusal of mental health treatment should not be treated as a crime any more that refusal of other health treatment; and

WHEREAS, the voluntary, comprehensive community-based programs resulting from State bills AB 34, AB 334, and AB 2034 provide the necessary outpatient treatment for individuals previously difficult to engage such as those who are homeless and exiting the jail system; and

WHEREAS. programs created in response to AB 2034 have been very effective in reducing hospital stays and jail time by providing intensive voluntary outpatient case management and support for individuals; and

WHEREAS. AB 1424, which became effective January 1, 2002, allows the medical history of a person to be considered in determining whether someone is gravely disabled or a danger to themselves or others, and whereas inclusion of this information at the certification hearings is expected to significantly impact decisions regarding involuntary inpatient commitment; and

WHEREAS, the National Council on Disability, an independent federal agency mandated to make recommendations to the President and Congress, extensively interviewed people with psychiatric disabilities and has recommended that:

"Laws that allow the use of involuntary treatments such as forced drugging and inpatient and outpatient commitment should be viewed as inherently suspect, because they are incompatible with the principle of self-determination. Public policy needs to move in the direction of a totally voluntary community-based mental health system that safeguards human dignity and respects individual autonomy" (Core Recommendation #1); and

WHEREAS, much of this resolution has been adopted from a resolution passed by the Mayor's Disability Council in San Francisco in November 2000; now, therefore

BE IT RESOLVED THAT, the San Francisco Mental Health Board urges the Mayor and the Board of Supervisors to support increased mental health funding for voluntary, community-based services and that the Mental Health Board specifically urges that the City and County of San Francisco take a position of opposition with regard to AB 1421 (Thomson); and

BE IT FURTHER RESOLVED THAT, the San Francisco Mental Health Board urges Community Mental Health Services in San Francisco, as well as the State of California, to develop ways of responding to the concerns of family members, such as by increasing mobile crisis services, by having support groups for family members as needed, and by case managers being open to hearing from family members as appropriate, and

BE IT FURTHER RESOLVED THAT, the San Francisco Mental Health Board urges the Mayor and the Board of Supervisors to provide funding for mobile crisis services in San Francisco 24 hours a day, seven days a week.

SUMMARY OF AB 1421 (Thomson)

Enacts Laura's Law, which establishes an outpatient treatment program. This bill defines assisted outpatient treatment (AOT) as services that have been ordered by a court.

Permits, in counties that apply for grants under this program, a court to order an individual to obtain AOT if the individual meets the following criteria:

- 18 years or older,
- likely to survive safely in the community with supervision,
- is eligible for involuntary commitment under LPS Act,
- has a psychotic disorder that has been treated within the past five years that was responsive to treatmentfor which s/he fails to engage in treatment for which the condition is substantially deteriorating, and AOT would be the least restrictive placement necessary to ensure her/his recovery and stability.
- has a mental illness that puts him/her at high risk for poor outcome for which s/he fails to engage in treatment for which the condition is substantially deteriorating, and AOT would be the least restrictive placement necessary to ensure her/his recovery and stability.

Permits the following to petition for an order for AOT:

- someone 18 years old or older who lives with patient,
- a parent, spouse, sibling or child 18 years or older,
- an institutional mental health services provider where the patient resides,
- a hospital where the patient is hospitalized,
- a licensed mental health provider who is treating the patient, and a parole/probation officer assigned to supervise the patient.

Outlines the requirements of a petition, which include:

- the affidavit of a licensed mental health provider who has examined the person no more than 10 days prior to the submission of the petition and who recommends AOT
- requires that the licensed mental health provider or his/her designee has made appropriate attempts to elicit the cooperation of the patient, but has been unsuccessful in persuading the patient to submit to an examination
- Requires the petitioner to give notice of the petition to the patient, the county office of patient rights, the patient's health care provider, if known, and the director of the county mental health department
- Requires the patient to have the right to be represented at counsel
- Requires the court to set a hearing for no later than three business days after the petition is received
- Requires the court to hear testimony.

Permits the examination of the patient by the court.

- If the patient does not appear, attempts to elicit attendance have failed, and the court articulates a factual basis for doing so, it may conduct the hearing in the person's absence

- Prohibits AOT unless a licensed mental health provider, who has personally examined the patient and reviewed his/her treatment history testifies in person at the hearing
- For persons who have refused to be examined by a licensed mental health provider, the court may request an examination by a court-appointed provider. If the person does not consent to such examination and the court finds reasonable cause to believe that the allegations in the petition are true, the court may order the patient taken into custody under the LPS Act.
- If the court finds that the patient does not meet the criteria for AOT, the petition shall be dismissed
- If the court finds the patient does meet the criteria for AOT, the court may order AOT for an initial period not to exceed 6 months
- AOT shall not be ordered unless the licensed mental health provider recommending AOT has submitted a written treatment plan to the court
- Provides that if, in the clinical judgment of the licensed mental health provider, a patient fails to comply with AOT, efforts were made to solicit compliance and the patient may be in need of involuntary admission to a hospital, that the patient may be taken into custody pursuant to the LPS Act
- Provides that failure to comply with an order for AOT is not alone grounds for involuntary commitment or contempt of court.
- Makes a violation an infraction.

VOLUNTARY AGREEMENTS

- Provides that a patient may enter into a voluntary agreement for services in lieu of AOT, or detention pursuant to the LPS Act
- Provides that patients may waive their right to an AOT or probable cause hearing to obtain treatment under a voluntary agreement, provided that a licensed mental health treatment provider states the person can survive safely in the community
- Provides that a voluntary agreement shall not exceed 180 days and shall be agreed to by all parties
- Provides that the voluntary agreement shall be in writing, approved by the court, and shall include a treatment plan developed by the community-based provider that will providing services
- The voluntary agreement may be modified by the court at any time
- Requires the court to designate a county department to monitor the patient's treatment and compliance with the voluntary agreement
- If a patient is noncompliant with the voluntary agreement, permits county counsel to file a statement of facts supporting the belief the patient is noncompliant
- Upon receipt of the statement of fact, permits the court to issue an order to detain the person up to 72 hours, excluding weekends and holidays, until a probable cause hearing may be held
- If a probable cause hearing was held prior to the approval of the voluntary agreement, requires the court to hold a final hearing within 14 days of detention

- If requested by the patient, requires the court to hold a hearing on the issue of noncompliance with the voluntary agreement within 72 hours of detention, which may occur at the same time as a probable cause hearing
- Provides that the patient has the burden of proving by a preponderance of the evidence that the facts alleged in the statement of noncompliance are false
- If noncompliance is found, allows the court to initiate a probable cause hearing

COUNTY PARTICIPATION

Requires DMH to provide oversight of grants issued pursuant to this bill and requires that services include:

- multidisciplinary provider teams
- medication
- individual or group therapy
- day or partial-day programming activities education and vocational training or activities
- alcohol or substance abuse treatment and counseling
- supervision of living arrangements
- any other services to assist the person to gain optimal living and functioning in the community

Prohibits involuntary medication without a separate court order issued pursuant to current statute

Provides that counties shall ensure that funds under this bill shall be used for new services

Provides that grantee counties must provide, or demonstrate they can provide all of the following for persons with the most persistent and severe mental illnesses:

- community-based, mobile, multidisciplinary, highly trained mental health provider teams that use high staff-to client ratios
- a clinical intervention that actively includes participation of the consumer, the appropriate family members, and peer counselors
- services in the location where the patient needs them
- a multidisciplinary team approach
- team services that are available to the client at all times
- teams that operate a ratio of no more than 10 clients per team member
- individually tailored services
- performance measurement to document improvement in obtaining employment or other gainful activity, obtaining skills of independent living, reducing hospitalization, incarceration or arrest and other improvements

Sunsets this program on 1/1/06

Opposition from statewide mental health client organizations base their arguments generally on a "fundamental philosophical difference," asserting that this bill:

a) Substitutes coercion for establishing a system of effective care that is sought voluntarily; and contains an enforcement mechanism and the authority to hold the AOT hearing without the person present if the person does not appear and appropriate attempts to elicit the attendance of the person have failed;

b) Creates additional layers of bureaucracy in a mental health system that already lacks accountability and would throw money in a direction that upsets the balance of civil liberties and social stability;

c) Allows persons in some counties to be subject to involuntary detention and psychiatric treatment under a standard less stringent than that required for persons in other counties in violation of the Equal Protection clause; and,

d) Provides services that would be very similar to those in other legislation, and that where system resources are sufficient, the vast majority of individuals that need treatment can be treated voluntarily.

Supporters generally argue that:

a) This bill provides both the legal and clinical treatment structure necessary to give severely disabled people, who have failed to engage in treatment after repeated offers of the best and most intensive services available, the support they need to achieve stability and meaningful recovery;

b) The assertive community treatment (ACT) model provided for is a proven, evidence-based, comprehensive, community treatment program for individuals with the most severe and persistent mental illnesses who are chronically resistant to treatment;

c) Scientific research demonstrates that sustained outpatient commitment can be highly successful for persons with serious mental illness if the following conditions are met: a) they have at least 180 days of service; and, b) receive an intensive array of services needed to address

d) This bill will give hope to Californians with mental illnesses that they will be going from a fractured system of care to one that provides continuity of care, support and an understanding of the multiple needs of those with serious and persistent mental illnesses.

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UNADOPTED MINUTES

Mental Health Board
Wednesday, April 10, 2002
1380 Howard Street, Room 537
San Francisco, CA 94103
6:30 p.m.

BOARD MEMBERS PRESENT: Ted Stinson (Chair); Robyn Buckins; Bob Douglas; Augusta Del Zotto; Carol Knight; Andrea Leung, L.C.S.W., A.C.S.W.; Toye Moses, Ph.D., M.P.H.; Rose Chung for Supervisor Aaron Peskin; Kate Walker; Idell Wilson; Sandy Yuen; Dennis Yun.

BOARD MEMBERS ON LEAVE: Bridgett Brown.

BOARD MEMBERS ABSENT: none.

PRESENTERS:
Richard Heasley, Executive Director, Conard House
Jonathan Vernick, Executive Director, Baker Places
John Nickens, Ph.D., Director of Clinical Services, Progress Foundation

OTHERS PRESENT: Linda Wang (CMHS Director of Adult Services); Carol Patterson; Deborah Sanders; Geneva Davis; Dorothy Shaffer (Parent); Helynna Brooke (MHB Executive Director); Rich Snowdon (MHB Administrator)

1.0 CALL TO ORDER AND CONSENT CALENDAR

The meeting was called to order at 7:00 p.m. by Ted Stinson, Chair.

> **RESOLUTION (MHB-2002-12): Be it resolved that the minutes of the Mental Health Board meeting of March 13, 2002, be approved as submitted.**
>
> **RESOLUTION (MHB-2002-13): Be it resolved that the Mental Health Board grants leaves of absence for the meeting of April 10, 2002, to the following members: Bridgett Brown.**
>
> **RESOLUTION (MHB-2002-14): Be it resolved that the Mental Health Board present the following certificate of gratitude to Carol Patterson: (See below.)**
>
> **RESOLUTION (MHB-2002-15): Be it resolved that the Mental Health Board send a letter to the Board of Supervisors in full support of the resolution proposed by Supervisor Ammiano urging the San Francisco legislative delegation to introduce**

an amendment to the California Constitution declaring the rights of the mentally disabled to housing, health care, and food to be public concerns and affirmative obligations of the State.

Resolution urging the San Francisco legislative delegation to introduce an amendment to the California Constitution declaring the rights of the mentally disabled to housing, health care, and food to be public concerns and affirmative obligations of the State.

WHEREAS, California's mental health system is inadequate in its resources and design to ensure quality mental health care to those who need it; and

WHEREAS, California spends billions of dollars addressing the consequences of untreated mental illness rather than spending that money more wisely on ensuring adequate mental health treatment; and,

WHEREAS, The Little Hoover Commission report of 2000 calculates that mental illness costs the California economy up to $10 billion annually in indirect costs, including losses in productivity; and,

WHEREAS, As a result of inadequate mental health resources, the criminal justice system has become a mental health service provider and a safety net in times of crisis for an increasing number of juveniles and adults who would be more properly served by a therapeutic and adequate mental health system; and

WHEREAS, There is in California a critical lack of mental health professionals, including an insufficient number of slots in academic programs to develop psychiatrists, social workers, and nurse practitioners; and,

WHEREAS, The overriding goal of mental health reform is ensuring that people who need care have access to high quality, tailored mental health services in their communities, in the least restrictive settings, designed to foster recovery, and that access to recovery is not barred by either societal discrimination or inadequate mental health treatment; and

WHEREAS, The text of the proposed amendment to the California Constitution is on file with the Clerk of the Board of Supervisors in File No. xx (see below), which is hereby declared to be a part of this resolution as if set forth fully herein; and now, therefore, be it

RESOLVED, That the San Francisco State legislative delegation be urged to introduce a bill proposing an amendment to the California Constitution to declare the rights of the mentally disabled to housing, health care, and food to be public concerns and affirmative state obligations; and, be it

FURTHER RESOLVED, That the lobbyists on behalf of the City and County of San Francisco be directed to garner support for such an amendment.

Proposed Amendment of Article I of the California Constitution Affirmative Obligations of the State toward the Mentally Disabled

Section 1. Preamble

California's mental health system is inadequate in its resources and design to ensure quality mental health car to those who need it. California spends billions of dollars addressing the consequences of untreated mental illness rather than spending that money on adequate service. California's counties have limited resources and cannot adequately meet their residents' mental health needs. Mental illness costs the California economy up to $10 billion annually in indirect costs. Direct costs for public and private and mental health care and substance abuse treatment in California are estimated to be $9.5 billion annually. The human cost of an inadequate mental health system is illustrated by the 1997 figure of 3,430 California suicides, the leading cause of preventable death.

The overriding goal of mental health reform is ensuring that individuals who need care have access to high quality, tailored mental health services in their communities, in the least restrictive settings, designed to foster recovery, and that access to recovery is not barred by societal discrimination, inadequate mental health treatment, or lack of housing and food.

Section 2. Section 32 is added to Article I of the California Constitution to read:

Sec. 32 (a) Persons with mental disabilities retain all the rights, privileges, opportunities, and responsibilities of other citizens, unless specifically limited by federal or state law or regulation.

(b) The housing, health care, and food needs of the mentally ill are public concerns and shall be provided by the State, in cooperation with its subdivisions, in such manner and by such means as the legislature may from time to time determine.

(c) The funding obligations for these needs shall be borne by the State. Funding for these needs shall not be subject to the appropriations limits set forth in Article XIIIIB of the California Constitution.

(Consent calendar passed unanimously.)

Mr. Stinson then presented the Certificate of Gratitude to Carol Patterson.

The Mental Health Board of San Francisco presents this
Certificate of Gratitude to:

Carol Patterson
For the pioneering role you've played since 1986 in empowering
mental health clients in San Francisco.
For establishing and running the BUILD Project, providing services
and now peer-counseling for people with psychiatric disabilities.
For being a founding member and leader of the Consumer/Family Member Task Force

of the Mental Health Board.
For your dedicated work with the National Empowerment Center.
For your advocacy for consumer employment in the mental health system through Jobs Now.
For being such an inspiration to so many consumer activists whom you've mentored.
We'll miss you and wish you the very best in your new position of leadership.

2.0 PRESENTATION: The Impact of Proposed Budget Cuts on Residential and Acute Care Programs in the San Francisco mental health system (50 minutes)

Mr. Stinson: Tonight's presentation is one in a series so we can understand how the possible budget cuts would impact our mental health system. We'll be looking at the three residential treatment programs.

Mr. Vernick: First let me thank you for having us come here to talk about our programs and the budget cuts. We don't often have the chance to address the Mental Health Board and it's a pleasure to be here.

Between Conard House, Baker Places, and Progress Foundation, we represent all the residential programs which provide services to adults with mental health problems and substance abuse services.

Baker Places has about nine different programs we operate. We have mental health, substance abuse, and AIDS programs. We provide residential treatment and various levels of care to people coming in with a range of problems. When someone leaves the hospital they can come to an ADU, an Acute Diversion Unit, a small, homelike environment. Then they can go to transitional housing.

The proposed cuts would eliminate all transitional housing.

Baker Places has two programs, adding up to 28 beds, which would be eliminated completely. What's significant is that the way in which our mental health system has operated for at least 30 years, people have had the opportunity when they are in crisis to get better through a psychosocial environment and return to the community. They have a chance to evaluate their experience and get support from people living in a residential community for 45 -90 days, then move on to independent living, such as coop apartments or a residential hotel. We give people the chance to figure out what stability is for them after the crisis and decide about volunteer work or paid work.

Unfortunately the level of the cuts were so high, Jo Ruffin found herself in a position where she had to take a look at the entire system to see if a whole modality could be cut. Since acute diversion housing couldn't be cut, and acute services, it fell on transitional housing to take the major share of the cut.

There is a base budget scenario. But then the Mayor also asked for a budget with a 10% cut. That's the budget the City is considering. I've worked in the system for 25 years, and there have been other years when there have been threats of cuts, but in none of those years were specific programs targeted for the cuts. We've been working hard to explain why is so essential for us to have this bridge—for people who can't go to a hotel or can't go to a shelter.

In terms of Baker Places, we have two programs we operate. Baker Street House has 16 beds and it was started in 1964. Robertson House, which used to be called Mandala House, has beds for 12 people.

Odyssey House which has a program for African American mental health clients is on the cut list.

Here's the scenario that's likely to happen as a result of the cuts. Many of the folks in transitional services couldn't be living in a less supervised setting than transitional housing. Many of them would still be in the hospital if they were in another county. But San Francisco has an excellent system of community-based support.

During the course of a year, 160 people move through those programs. If cut, many of them might have to go back to the hospital. So the cost to the City would be considerable. Whereas we can deliver a much lower cost bed. Our rate is $150-200 per day.

Mr. Heasley: Conard House is an organization that has been specializing in social rehabilitation programs for mentally ill adults since 1959. It was started by two social workers who recognized the need for placements for people coming out of Napa State hospital.

We have five major programs. We have the Jackson Street Residential Treatment Facility which is located at Jackson and Fillmore streets, and which was the original facility.

Then we also have: co-op apartments, SRO hotels, a money management program, and a vocational training and placement program, which includes Conard Cafe at 710 Montgomery and a janitorial program

We serve about 1200 people a year.

Under the budget cuts, our flagship program, Conard House, is scheduled to lose $600,000. We are serving 80-100 people a year there. With shorter lengths of stays, we expect 100 people to be served this year. We have a bed capacity of 24. Eight of the beds are designated for our Asian residential treatment program. Currently we have staff who speak six different Asian languages.

So one of the things that would disappear were transitional residential treatment to be cut, would not just be people served in the general population, but our services for the monolingual Asian clients.

Our clients come from predominantly higher levels of care. Usually from the hospital or long-term locked facilities, and they are coming through the acute diversion units that progress Foundation is responsible for. So the way to think about what the impact would be is that those people need 24-hour care, and they can't go to a residential setting, and all the alternatives are more expensive.

So the equation they have in this budget is cost savings, but it has the reality of shifting the cost to another location where the cost per day is much higher. Sooner or later anybody who is not placed in an appropriate placement will have to be placed in a higher cost placement.

These are made to look like cost savings in the short run, but are cost generators in the long run.

That's just the dollar cost, but I think there is a much more serious human cost that a dollar amount can't be placed on. We have many people who are working very hard to establish a life in the community. These cuts have the effect of blocking the path back to the community.

Mr. Vernick: All three of these organizations actually own the houses that these services are provided at. That's six houses. You know how difficult it is to get the use permits and all the objections that can happen in the neighborhood. These are non-renewable resources. Most of these houses were bought a long time ago for what today seems like very little money.

Dr. Nickens: Progress Foundation has been around for a long time. All three of these residential treatment organizations started in the same way with a social service and political agenda about human rights for people with a mental health diagnosis.

For us the cut would eliminate 23 beds—one program in the Mission and one in Pacific Heights.

All of our programs take people from higher levels of care. We try to provide an environment of opportunity and a path for determining one's own recovery process. We use relationships to do this. The thing that our clients miss the most in their lives is relationship.

It's a very special thing to offer people the richness of relationship as well as the services we provide. That's the focus of all these programs. And the cuts will take much more than money away from our clients.

Also on the cut list are all the private inpatient beds. The fact is that people need help when they need it, and we can't just take away everything at the same time: transitional housing, day treatment, and private hospitals.

When these houses are gone, they're gone. There is no way we could open one of these in today's market. And of course all of the approval issues make it pretty difficult to open a new program.

Since Northeast Lodge, a 30-bed program, closed in the early 90's, the gain in transitional programs has been only 16 beds. So there has been no net addition since the early nineties.

So we're cutting something that doesn't have a long way to go to completely collapse. By the way I want you to know that our county colleagues are also in pain about this.

I think everybody on this Board is committed to a non-institutionalizing, recovery-oriented, choice-oriented system of treatment. It seems to me to dismantle the programs that champion this very ethic is tragic. It's because of these kinds of programs that the state is now taking up the philosophy of empowerment and rights and justice. The cuts are going the wrong direction. There is a need to increase residential treatment by 40-70 beds over the next several years.

We asking for help not just for our individual programs, but for all the programs together. We're asking for the system to remain whole.

We would ask your help in any way you can offer it.

Ms. Leung: I personally work with all three organizations. All the staff are wonderful. I just hate to see any of these programs being affected directly or indirectly.

Ms. Knight: What about your client's families? Are any of the family members directly involved in helping to advocate for their loved ones?

Mr. Vernick: Generally we've been trying to advocate on different organizational levels. We have the Human Services Network, which is an organization of 85-90 service providers doing advocacy together. We just recently testified at the Health Commission. Many clients were present to assert their concerns. But a lot of the people who find themselves in the mental health system have lost touch with or are not in connection with their family members. We haven't made a direct effort at this point to solicit family members. And we couldn't do that anyway without the permission of the client. It's better to do that through NAMI.

Mr. Heasley: We had a large number of our residents who came forward when they heard about budget cuts and wanted to know what they could do, so we laid out some alternatives. A fair number of letters and e-mails were sent in to the Supervisors, the Mayor, and the Health Commissioners, but we left it up to the clients to do what they wanted to do. A large number of them appeared before the Health Commission.

They are also very anxious about this, and it looks like the cuts could happen. We have to keep operating each day, and we don't want to see hospitalizations increase as a result of people's anxiety about this.

We're hearing lots of rumors and seeing lots of changes, sometimes on a daily basis. There is a lot of chaos. We're hoping that these programs won't be closed.

Mr. Vernick: It does get the attention of the Supervisors, if you remind them that these programs are owned by the community providers and have conditional use permits. And the cost is offset by Medi-Cal. So every dollar spent brings back about 35 cents. These are the only services that provide housing to people while they are receiving treatment.

Dr. Del Zotto: When different political and civic leaders come up to you trying to justify removal of transitional programs, what justification do they use?

Mr. Heasley: The argument in favor of this is that it's a program that provides a benefit to a small number of people at a relatively higher cost compared to other things that could happen. If you look at it from a cost/benefit point of view, the cut looks like it's saving money in the moment because these programs serve a relatively small number of people.

Mr. Vernick: Most members of the Board of Supervisors don't know what transitional housing is or that these programs were planned to be cut. There is not an ideological position about these cuts. The education piece can make a big difference.

Ms. Buckins: Would you say that they cut the programs and these people in these house will have to go back to the hospital, but ultimately won't they end up homeless? It seems like a ten year old could figure this out.

Mr. Heasley: Some people would go back to the hospital until they no longer meet the criteria for medical necessity. Then they would then be eligible for discharge, and where could they go that they won't end up back in the hospital or out on the street? They'll be bouncing back and forth between the street and the hospital.

Dr. Nickens: We need to ask, What do you think really helps people get out of this system? Rather than asking, What do you think people need to be in the system? It's a matter of your world view. There are services that are oriented to serving people, and they have dedicated staff who do good work, but their basic orientation by necessity is to support and help people maintain themselves within the community mental health system. But they are not equipped to help people exit the system. It does cost more in the short run to help somebody get out of the system than stay in the system. You have to decide if that's worth it.

Dr. Del Zotto: Do you have information on the rate of relapse?

Dr. Nickens: Yes, we do, but let me tell you the problem with it. This is true for all types of services. The problem is that there are so many intervening people in the individual's life that you can't tell who's having what impact. It's great to have the rich matrix of programs we have in San Francisco. If you go to Los Angeles you basically have the street or the hospital. We have residential treatment, outpatient clinics, case managers, and health providers.

Mr. Vernick: If you compare people's level of functioning for three months prior to admission and three months after discharge, you find the number of hospital days decreased by 60%.

Mr. Douglas: I was a nonprofit manager. One of the things we told Board members is don't get all your money from one place. Are you going to find other sources of money?

Dr. Nickens: That's a big debate inside the nonprofit community. We do a little bit of that. We get some HUD money to initiate housing programs. But the reason we pursue most of our money from the county, is that we believe strongly that people who are in need should be supported by the community in which they reside.

We started a program in Pacific Heights a couple of years ago. There were multiple lawsuits, and community wrangling. It was an opportunity to stand up for social justice and do education about why people have a right to live here.

Mr. Douglas: Why don't you go to other funding in the city, like foundations? You shouldn't put all your eggs in one basket.

Mr. Vernick: We do leverage dollars from our services, we bill Medi-Cal for a portion of the cost of our services. We bring a lot of resources to the table with any of these programs so it's attractive to the city. No one else could step up to the table and do anything like what we're doing particularly with regard to housing.

Mental health is not sexy; it's extremely difficult to find funding. Mental health is one of the hardest programs to fund. Mental health clients have a difficult time finding a group in the community at large who embraces their issues.

Dr. Nickens: Foundations generally don't fund operations. I don't want to duck the public policy issue. I don't want money from New York. I want our elected representatives to grapple with the problem.

Mr. Stinson: This is a fascinating discussion, which I wish could go on for many hours. But we're going to have to bring it to a close due to time.

Ms. Brooke: We are legally obligated to serve people in crisis. We are not legally obligated to help people transition, even though that makes sense. It's up to us as advocates to let the Mayor and the Board of Supervisors know how critical these programs are.

3.0 DIRECTORS REPORTS

3.1 Report from the Director of Community Mental Health Services

Ms. Wang reported for Jo Ruffin: First I wanted to respond to the question about diversifying the funding base for the residential programs. We have been blessed in San Francisco with providers who are very committed to our public mental health clients. And they are not always embraced by the community. When we try to start a new program we often get concerns and protest from the community.

It makes good sense to diversify funding, but for residential mental health programs, the bulk of their funding will have to come from the public sector. Apart from grants for pilot programs, there is no other source of funding that they can really tap.

The Mayor has given the Board of Supervisors a provisional budget, but it is not balanced. The City's fiscal future is looking better, but we can't tell at this point how much better. We are a public safety net and we have to make sure the safety net doesn't have a bunch of holes.

We're trying to minimize the impact of any cuts and the number of people the cuts will affect. The mental health system serves about 21,000 people annually.

The Directors written report was distributed.

Budget Update. The Mayor's Office submitted an unbalanced budget to the Board of Supervisors on April 1, and followed up with a presentation on April 9th. The Mayor's Office will work with the Board of Supervisors to determine the best approach to balancing the budget. At this time, the Mayor's Office has not advised the Department as to whether or not it will require Department funds to balance the budget. As stated in a prior update, the Department presented a 10 percent General Fund reduction plan as required by the Mayor's Office for use in the event the budget can't be balanced City-Wide. These reductions would pose a significant impact to Community Mental Health Services, which prepared a plan equal to approximately $11 million in reductions, including both General Fund and matching revenues. The reductions were spread across most treatment modalities and would impact both civil service and contracted programs. The Department is anticipating more information regarding the use of this plan in late April once the Mayor's Office has the opportunity to analyze all of the departmental budget submissions.

Program Moves. Mission Mental Health Services (outpatient clinic) and the Mission ACT program (one of three SPR single point of responsibility programs) have just moved to their new offices at 2712 Mission Street. These programs serve about 1400 clients annually, most of who reside in the Mission area. Staff who are bilingual in Spanish/English are available to provide treatment and case management services. These programs have worked collaboratively with programs such as the Treatment Access Program and Mission Council to develop services for the dually diagnosed, and to cross-train staff. The clinic uses a harm reduction approach to the dually diagnosed, providing assessment, acupuncture services and harm reduction groups. The staff have also developed a successful approach to responding to the volume of requests for service. Case Management and treatment services have helped to reduce hospital use. The site, newly renovated, is located in the heart of the Mission District of the City, at Mission and 23rd Streets. The CMHS residential care support, bed committee and long term care staffs will soon relocate and join these programs at this site.

AB 3632 Transition. As of May 1st, 2002, a civil service unit will be created to provide AB3632 assessment service for children and youth enrolled in special education. This function was previously performed by a unit under Family Service Agency. AB 3632 Assessment and Case Management are services mandated by the State for special education students who are experiencing learning difficulties as a result of having emotional problems. Since this is essentially a centralized intake function, the department negotiated with Family Service Agency to convert the unit from contract to civil service status. The unit will be housed temporarily at 1380 Howard Street, pending the identification of a permanent site.

Staff Training, Recruitment, and Retention Focus Group. At the request of the California Institute of Mental Health, the Child, Youth and Family Section of CMHS and the Child Welfare Section of DHS organized an ethnic focus group for African American social workers to discuss issues around training, recruitment, and retention. The focus group was held on March 26, 2002 and was well attended by African American social workers from both departments. This is one of four ethnic focus groups held statewide by CIMH to inform the State Department of Mental Health of the barriers in the recruitment and retention of minority mental health professionals. Information collected from the focus groups will be reviewed by CIMH to make recommendations to the State Department of Mental Health and the Legislature.

Program for Firesetters. Comprehensive Child Crisis Program will receive a work order from the San Francisco Fire Department to further its collaborative work with the SFFD in providing outreach and clinical service to junior firesetters. SFPD recently received a FEMA grant for both fire prevention education and the Junior Firesetter project. The Junior Firesetter Project is a collaboration of the following public department partners: SFPD, SFUSD, DPH, and DHS, with the SFPD Arson Investigation unit providing the lead.

Services Provided to the SFPD. In conjunction with the San Francisco Police Department, the Comprehensive Child Crisis Program provided de-briefing services to the Bayview Hunters Point community residents following an incident involving several youth from the community and the SFPD..

Theresa Gallegos. Congratulation to Ms. Theresa Gallegos, a community health worker with the CMHS Family Involvement Team. Theresa has been elected president of the Citizens Advisory Committee, which is mandated by Prop. D to oversee the allocation of $30,000,000 for youth programs in San Francisco. Ms. Gallegos received a commendation from the San Francisco Youth Commission on March 4, 2002, for all her past, current and future advocacy on behalf of children with disabilities, and children from disadvantaged communities, and for her inspiration to all youth advocates as a positive role model.

AB 2034 Summary and Present Status. San Francisco Community Mental Health Services (CMHS) was awarded an AB2034 grant by the State of California Department of Mental Health (DMH) in November of 2000. A supplemental application to that original grant was submitted in November of 2001. Governor Davis announced on March 26, 2002 the awardees for the supplemental and San Francisco did not receive additional funding. The State gave three reasons for not funding the supplemental request.

Below we will provide a response to those rationales, a summary of the current status of the AB 2034 program, a summary of the supplemental application, and a timeline of accomplishments.

Response to State Critique:

The State considered San Francisco under enrolled as of June 30, 2001. The supplemental application reported that as of September 2001 we had enrolled 112 (93%)

of the 120 clients promised to be enrolled, we had seen hundreds more in the engagement process. We did not meet the June 30, 2001 target but as of March 2002 we have 123 clients enrolled.

The State did not think we met the criteria for 24/7 coverage and were only open 8-5. The City process to reimburse employees to work evenings did take time; by October of 2001, and in the application, we presented the Civil Service letter informing the Team that waivers had been granted for employees to work 24/7. The program is now 24/7.

The State was concerned about the slow start of housing for the clients. The San Francisco AB 2034 project was both developing dedicated supportive housing through the DPH Housing office while using housing vouchers for clients until the facilities opened. The AB2034 project at the application date had 79 clients in housing. The dedicated supportive housing hotels are scheduled to be open in May and June.

The status and outcomes for the San Francisco AB 2034 program as of February 2002:

Enrolled-123
Reached out to(unduplicated)-343
Number of outreach contacts-741
Reduced enrolled clients hospital days by-53%
Reduced enrolled clients jail days- 75%
Consumers maintaining housing-86
Consumers in shelters-9
Employed clients-8

Supplemental application summary:

The supplemental application had two parts: a) a request for expanded funding for 19.5 months of $1,463,326, The 19.5 month request was to increase the number of enrollees by 12 homeless transition age youth, expand the number of permanent housing units by 67, and establish a wellness center for the clients. Sixty nine percent of the part a expanded funding request was for supportive housing. The second part (b) of the supplemental was a request for one time funding of $1.857,240. The one time request was to provide three years of rent subsidies in a housing fund; supportive housing was 100% of the three-year funding. The entire proposal was designed to provide supportive housing for 67 clients for a period of five years, the supported housing request was 86% of the total (a&b) supplemental request.

Dr. Moses: Your statistics for the MOST Team show a reduction of 75% in jail time. How did that happen? Ms. Wang: It's through intensive case management. We have tried to instill the philosophy of recovery in this program. If you have a mental illness, it does not mean that your situation is hopeless and the illness doesn't have to be forever. There is possibility and opportunity. We've provided training for our staff so they can make the recovery model work with these homeless mentally ill clients.

Ms. Patterson: I'm on the advisory board for the MOST Team, and want to give an endorsement of the program. People who came in as clients are now on the advisory board and they are really helping to empower the other clients.

Ms. Wang: The State report on AB 2034 funding featured our San Francisco program.

3.2 Report from the Executive Director of the Mental Health Board

Ms. Brooke: Supervisors Gonzalez and Sandoval were upset about a grant for more beds at Juvenile Hall, and were opposed to this on a policy basis. They have now put forth a proposal that all applications for grants of $50,000 or more shall be subject to approval by the Board of Supervisors. Because of the length of time it takes to get such approval, this could mean that many grants could not be applied for. This proposal could be crippling to City departments.

4.0 MENTAL HEALTH BOARD COMMITTEES

For discussion and proposed action

4.1 Report of the Chair of the Board and Executive Committee

Mr. Stinson: Alex Kitzes asked me to announce that he will be resigning from the Mental Health Board. He is taking on a 20-hour a week research job in addition to his regular full time job, so he won't be able to keep up with his Board commitments.

Our Annual Reception will be held in the Mayor's Conference Room on May 16th.

Ms. Leung: Our three former committees are inactive right now. The budget issue is our biggest priority, so the Executive Committee decided that we have to put the regular committees aside and work on budget issues in two different formats.

I will be the leader of the Media Strategy Committee, which will focus on talking to reporters or writing articles to encourage funding for mental health services, and to give the Board some recognition. Both committees will have to act immediately because the public hearings are coming up. This committee will meet the first Wednesday of the month

Ms. Walker: What my committee will be is a Speaker's Bureau. There are two problems we need to consider. I need help knowing when the hearings will be held, and what the people will say. If you've had practice in testifying, you'll have no problem. If you haven't done testifying before this is a lovely opportunity to try it out. We can help you prepare for this. The first meeting of this committee will be April 23 rd.

Mr. Stinson then asked for volunteers to co-chair these committees. He then appointed Idell Wilson to co-chair the Media Strategies Committee with Andrea Leung. And he appointed Robyn Buckins to co-chair the Speakers Committee with Kate Walker.

Mr. Stinson introduced the resolution urging the Mayor and the Board of Supervisors to oppose AB 1421 regarding: Mental Health Involuntary Outpatient Treatment. (Attachment B)

There was a discussion by the Board. Board Member Robyn Buckins requested permission to abstain from the vote, which was granted by the Board. A vote was taken with the following results:

Voting in favor of the resolution calling on San Francisco to oppose AB 1421: Robert Douglas, Carol Knight, Toye Moses, Kate Walker, Idell Wilson.

Voting against the resolution calling on San Francisco to oppose AB 1421: Augusta Del Zotto, Andrea Leung, Ted Stinson, Sandy Yuen, Dennis Yun.

The vote was tied at five for and five against, and therefore the resolution did not pass.

4.2 State Liaison

No report apart from AB 1421.

5.0 PUBLIC COMMENT (10 minutes)

Ms. Patterson: The Mayor's Disability Council recommended opposing AB 1421. Instead of putting money into forced outpatient treatment, the Rand study says we're not sure forced outpatient works, and what is really needed are more mental health programs. Programs like AB 2034 are very effective, and you don't have to change the law to start those. You just have to get the money for them.

Ms. Sanders: I have taken a position as a consumer that is different from the main consumer position. But at this point with no money to support the mandate Ab 1421, it doesn't make any sense. This bill does not affect the LPS conservatorships. Civil contempt is all that could happen to a consumer who refused involuntary outpatient treatment under this bill, and criminal contempt could not happen.

There being no further business the meeting was adjourned at 9:06 p.m.

SAN FRANCISCO MENTAL HEALTH BOARD

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MEETING OF THE MENTAL HEALTH BOARD

Wednesday, May 8, 2002
1380 Howard, Room 537
6:30 p.m.

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AGENDA

Public comments will be taken for each agenda item.

1.0 CALL TO ORDER AND CONSENT CALENDAR (10 minutes)
For discussion and proposed action

1.1 Call to Order and Announcements from the Chair

1.2 Consent Calendar (Attachment A)

1.2.a PROPOSED ACTION: Be it resolved that the See minutes of the Mental Health Board meeting of April 10, 2002, be approved as submitted.

1.2.b PROPOSED ACTION: Be it resolved that the Mental Health Board grants leaves of absence for the meeting of May 8, 2002, to the following members: Carol Knight, Sandy Yuen.

2.0 PRESENTATION: City Attorney's Office Presentation of the Sunshine Regulations for Board Meetings. (50 minutes)

Presentation of the Sunshine Act and its implications for the Mental Health Board and its members by staff from the San Francisco City Attorney's Office.

3.0 DIRECTORS REPORTS (30 minutes)
For discussion

3.1 Report from the Director of Community Mental Health Services
A report on the activities and operations of Community Mental Health Services, including budget, planning, policy, and programs and services.

3.2 Report from the Executive Director of the Mental Health Board
A report including updates and announcements regarding the activities and operations of the Board.

4.0 MENTAL HEALTH BOARD COMMITTEES (20 minutes)
For discussion and proposed action

4.1 Report of the Chair of the Board and Executive Committee
The chair will report discussions and actions of Executive Committee. Committee chairs will describe the two Ad Hoc Committees and seek participants.

4.1 a PROPOSED ACTION: Be it resolved that the Mental Health Board urges the Board of Supervisors of the City and County of San Francisco fund the Mobile Crisis Team for 24 hours per day, seven days per week.

4.2 State Liaison
A report on developments regarding mental health services, policy, and funding at the state level, including the California legislature, the State Department of Mental Health, and other statewide advocacy or policy organizations.

5.0 PUBLIC COMMENT (10 minutes)
This is an opportunity for members of the public to address the Mental Health Board on items of interest to the public that are within the subject matter jurisdiction of the Mental Health Board. Additionally, public comments will be taken for each agenda item.

This agenda and all attachments can be viewed at: www.ci.sf.ca.us/mental_health. Attachments are also available at the Mental Health Board Office, 1380 Howard Street, Suite 510, telephone 255-3474.

DISABILITY ACCESS

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MENTAL HEALTH BOARD
ATTACHMENT A
May 8, 2002

CONSENT CALENDAR

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1.2.a **PROPOSED RESOLUTION: Be it resolved that the minutes of the Mental Health Board meeting of April 10, 2002, be approved as submitted.**

1.2.b **PROPOSED RESOLUTION: Be it resolved that the Mental Health Board grants leaves of absence for the meeting of May 8, 2002, to the following members: Carol Knight; Sandy Yuen.**

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MENTAL HEALTH BOARD
ATTACHMENT B
May 8, 2002

PROPOSED RESOLUTION (MHB-2002-xx): TO EXPAND THE MOBILE CRISIS TREATMENT TEAM TO 24 HOURS A DAY, 7 DAYS A WEEK

WHEREAS, the Mobile Crisis Treatment Team, which is a program of Community Mental Health Services in the Department of Public Health, has exceeded all expectations since 1995 when it was founded, and

WHEREAS, Mobile Crisis is a key element in the overall cost-effectiveness strategy of Community Mental Health Services, and

WHEREAS, Mobile Crisis provides crisis intervention in such a way that it reduces the need for using the most expensive services, such as Psychiatric Emergency Services or the psychiatric inpatient wards at San Francisco General Hospital, and

WHEREAS, Mobile Crisis provides early intervention in such a way that the number of mental health crises in San Francisco are significantly reduced, and

WHEREAS, the San Francisco Police Department is a strong supporter of Mobile Crisis, frequently calls upon Mobile Crisis, and has a close working relationship with Mobile Crisis, saving the police department significant costs in terms of officer time, and freeing up officers for doing other police duties which should be their focus, and

WHEREAS, Mobile Crisis has been a godsend to the families of the seriously mentally ill, and is a service family members can call upon when they see a loved one showing the warning signs of distress or decompensation, and

WHEREAS, the staff of Mobile Crisis have been honored by the Mental Health Board for having a deep commitment to their mission and their work, and

WHEREAS, in challenging financial times, it is more important than ever for the City to employ the most cost-effective strategies possible in delivering public health services, now, therefore,

BE IT RESOLVED that the Mental Health Board recommends in the strongest possible terms to the Health Commission, the Board of Supervisors, and the Mayor that the Mobile Crisis Treatment Team be funded at a level which allows it to operate 24 hours a day, seven days a week.

SAN FRANCISCO MENTAL HEALTH BOARD

SEAL OF THE CITY AND COUNTY OF SAN FRANCISCO

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DISCUSSION NOTES
Mental Health Board
Wednesday, May 8, 2002
1380 Howard Street, Room 537
San Francisco, CA 94103
6:30 p.m.

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BOARD MEMBERS PRESENT: Ted Stinson (Chair); Andrea Leung, L.C.S.W., A.C.S.W.; chance martin; Toye Moses, Ph.D., M.P.H.; Rose Chung for Supervisor Aaron Peskin; Idell Wilson.

BOARD MEMBERS ON LEAVE: Bridgett Brown; Robyn Buckins; Augusta Del Zotto, Ph.D.; Bob Douglas; Carol Knight; Kate Walker; Sandy Yuen; Dennis Yun

BOARD MEMBERS ABSENT: none.

PRESENTERS: none.

OTHERS PRESENT: Linda Wang (CMHS Director of Adult Services); Dorothyt Shaffer (Parent/Health Professional); Emeric Kalman; Joel Luebkeman; Helynna Brooke (MHB Executive Director); Rich Snowdon (MHB Administrator)

PLEASE NOTE
There was no quorum for this meeting of the Mental Health Board, therefore no action items were considered and no votes were taken.

The discussion started at 6:45 p.m.

Mr. Stinson: I'd like to introduce our newly-appointed Board member Chance Martin.

Mr. Martin: I work at the Coalition on Homelessness where I edit our newspaper, the *Street Sheet*. I'm on the Executive Committee of the International Association of street newspapers. We're trying to build a non-governmental organization like Amnesty International.

I've been appointed to a Public Interest seat by Supervisor Chris Daly. The Homeless Coalition has been doing cutting edge advocacy on mental health issues. I formerly collected SSI for a psychiatric disability. I'm always quick to point out that only one of ten people with mental illness like me return to full employment and I'd want to use my participation on this body to help change that.

Mr. Stinson: Due to illness and other commitments on the part of Board members, we won't have a quorum for our meeting tonight. After talking with the two attorneys who were here from the City Attorney's office, we decided that we'd invite them back when more Board members are here. We can proceed through our agenda, as long as we don't deal with issues that require quorum.

DIRECTORS REPORTS

Ms. Wang, reported for Jo Ruffin: There was a budget hearing before the Board of Supervisors yesterday. The Department of Public Health was asked by the Mayor's office to present the whole picture of the $25 million in cuts which is possible if the city's economy doesn't improve. There has been a fair amount of support for the Health Department's budget and Community Mental Health Services. But we don't know at this point what the Mayor will decide.

On Monday, Bob Cabaj, currently the CMHS Medical Director, was appointed the Behavioral Health Services Director for the Department of Public Health. Barbara Garcia, the Deputy Director of Health for community health programs announced that Dr. Cabaj would be taking that position, and then Jo Ruffin, Director of Community Mental Health Services, and Jorge Partida, Director of Community Substance Abuse Services, would be Bob's deputies.

The key is that the planning will begin on how we will become an integrated behavioral health service. There is so much overlap in terms of what clients present that there needs to be a much better approach developed to help people with dual diagnoses.

Barbara Garcia said she was going to meet with the leaders of the advisory councils to talk about this change of structure.

We are about to submit a proposal to fund alternatives to long-term care. We decided to see if we couldn't do better at helping African American male clients return to the community. What we find is that we often have great difficulty placing African American males, and they are more likely to return back to long-term care, and have longer stays in long-term care. We've been studying this issue for the past three years. We want to be able to track these clients better, and create a recovery center, so we can help these clients move on in their lives. We're looking at developing several residential options.

The percentage of African American males in long-term care is 28%, which is disproportionate in relation to number of African Americans in the system which is 24%. Both of these numbers are very disproportionate compared to the total African American population in San Francisco which is 7%.

Dr. Moses: I think it's time that DPH respond in a culturally competent way to this need. Twenty-eight percent is a very high percent. This is very needed in mental health.

Mr. Martin: The reading I've done says that African Americans are generally medicated at higher levels. And over medication can be a long-term problem.

Ms. Shaffer: Is that proposal only for adults? Ms. Wang: Yes, it's just for adults.

Ms. Shaffer: If you go up to Juvenile Hall, what you see again is a disproportionate number of African American males. And they spend so much time there.

Member of the public: What kinds of diagnosis would cause someone to go into locked facilities? Ms. Wang: It's not the diagnosis per se. You can have two people with the same diagnosis, one in long-term care and one living successfully in the community.

Ms. Leung: It's the ability of self care that's the issue. Specifically, can the client take care of food, shelter, and clothing.

Ms. Wang: Yes, it's a question of grave disability, and being unable to care for themselves. The long-term facility in our county is the Mental Health Rehabilitation Facility on grounds of San Francisco General Hospital. It's been open for five years and has a rehabilitation philosophy. The average stay is 6-9 months. When the MHRF first opened, we were taking in people who had been in institutions for a long time and it took longer to get them ready to live in the community than we expected. A key advantage of having an in-county long-term care facility, is that it's easier for family and friends to visit and provide support and stay connected.

Dr. Moses: With regard to the county jail, there is a disproportionate number of mentally-ill African Americans in jail. And now Jail Psychiatric Services is being targeted for cuts.

Ms. Wang: Part of this proposal is training our existing providers in more successfully working with the African American population. But the competition for the grant will be very stiff.

Ms. Shaffer: Does Supervisor Maxwell realize the Child Crisis Center is in her district? What might help our Supervisors know where are the highest needs of mental heath?

Ms. Brooke: The Police Department did a color map of 800 calls, which means calls for mental health crisis. The highest number is still around the Tenderloin area.

The Director's written report was distributed:

Budget Update. The budget for FY 02-03 is still under review at the Mayor's Office. The Board of Supervisors Budget Committee held a hearing on May 7, 2002 on the Department of Public Health budget, including the $25 million in general fund reductions that the Department submitted in the event that the City's fiscal outlook for the next fiscal year showed a significant projected deficit. The Committee accepted public testimony at this hearing. There is no word yet regarding whether and to what extent mental health cuts will be needed.

Behavioral Health. "Improve integration of services for target, vulnerable and at-risk populations who need multiple services" is strategy 1.6 of the Department's Strategic Plan. Following this direction, Barbara Garcia, has been leading the development of a comprehensive model of care for clients impacted by substance abuse, mental health, and physical health. Based on this work, the Department is embarking on a three-year plan to implement a Behavior Health model of care. Dr. Bob Cabaj has been appointed Behavior Health Director. Dr. Jorge Partida and Jo Ruffin will act as the Deputy Directors of Behavior Health. Planning for the changes needed for Community Mental Health Services and Community Substance Abuse Services to become Behavioral Health Services will occur in the coming months. Barbara Garcia, Deputy Director for Community Health Programs, plans to meet with the leadership and staff of the four boards/councils for CMHS and CSAS in the very near future. Consumer, family member and provider input will be elicited.

Client Flow Pilot. The client flow pilot to eliminate administrative days at San Francisco General Hospital Psychiatric Inpatient Units and reduce reliance on fee-for-service hospitals has officially begun and will run through July 31, 2002. In the two month preparation phase (March and April 2002), under the leadership of Gene O'Connell, Chief Executive Officer of SFGH, Barbara Garcia, Deputy Director for Community Health Programs, and Liz Gray, CMHS Director of Long Term Care, administrative days dropped by 59% compared with administrative days for the two months (January and February 2002) prior. The number of admissions increased by 28%.

Wayne Clark, PhD. Wayne Clark, a senior administrator in CMHS has been selected as the new Director of Behavioral Health Services for Monterey County. Wayne will assume his new duties on May 6, 2002. Wayne has worked for the Department of Public Health for 28 years. Among Wayne's major assignments have included the director of the Alcoholism Evaluation and Treatment Center and Director of Substance Abuse Services. Most recently Dr. Clark has been and Executive Team member in CMHS with a wide variety of assignments including oversight of the residential treatment services, the CMHS liaison to the AIDS Office, CSAS, and Housing and Urban Health, and the criminal justice system. Wayne did much grant writing during his career with DPH and was responsible for bringing into DPH many millions of dollars. Wayne's departure is a major loss for CMHS and for DPH as a whole. However, his new job is richly deserved and we all wish him the best.

CMHS Laboratory Services Manual. CMHS is now offering increased access to laboratory services to CMHS providers and consumers through Quest Diagnostics, St. Luke's Hospital Clinical Laboratory, and Chinatown Medical Laboratory. A CMHS Laboratory Services Manual has been developed that includes a list of patient service centers with their phone numbers and hours of service, a copy of the laboratory test formulary, the custom "CMHS Laboratory Test and ECG/EKG Requisition" with instructions for completing the form, and a list of ICD-9 codes that are required by Medicare for certain tests. A copy of the manual has been provided to Medical Directors and in-services are being given during April and May at CMHS clinics.

Revised Pharmaceutical Sales Representative Policy. A revised policy and procedure regarding the activities of pharmaceutical company representatives (PCRs) was recently approved by CMHS. The policy applies to both civil service and contract clinics, and was developed with input from medical directors and clinic directors at those sites. Key features include: PCRs must register centrally with CMHS Pharmacy Services and are required to wear their CMHS registration badge while conducting business with clinic staff. PCRs must contact and obtain approval from either the medical director, psychiatrist in charge, or clinic director prior to visiting a clinic. PCRs may provide samples or vouchers only upon request of authorized prescribers and only for drugs that are on the CMHS formulary in unrestricted status (no sampling of non-formulary or prior authorization drugs). Educational in-services require approval from both the medical director and clinic director. A meeting with the PCRs, the CMHS Medical Director and the CMHS Pharmacy Director is scheduled on May 14, 2002 at 1380 Howard Street to review the policy, discuss the changes and answer questions.

Protocol Approved for Clinical Pharmacists. A new procedure and protocol was recently approved to formally recognize the expanded role of clinical pharmacists in providing increased support to medical staff through medication management for referred patients. A new law (AB 826) passed in January, 2002 expands pharmacists' scope of practice in outpatient settings to include initiating and adjusting drug therapy under protocols developed by a multidisciplinary group of health professionals including physicians. The CMHS protocol delineates specific criteria for patient referral, for initiating and adjusting medication therapy, and for pharmacist training and supervision by medical staff. Each clinic is able to make specific modifications to the protocol as an amendment. While clinics and physicians are not required to utilize services provided by clinical pharmacists, many clinics have found the use of pharmacists as physician extenders to be cost-effective. Clinical pharmacists are currently providing services at the following sites: Center for Special Problems, Chinatown/North Beach, Mission Team One, Mission Team Two, Mission ACT, OMI, and South of Market Mental Health.

IMD Proposal. San Francisco County is applying for funds from the California Department of Mental Health in response to an RFA titled "Strategies for Community Placement Alternatives for Individuals Residing in Institutions for Mental Disease (IMDs)." The San Francisco proposal, if funded, will create an African American Focused Transition Program for IMD clients who are ready for community placement. Specifically, the program will provide culturally appropriate community alternatives to African American clients who have had difficulties in staying out of long term care. This will include several housing options alongside case management that will be tailored to the needs of the African American clients. There will be provision for addressing the needs of the dually diagnosed clients as well. The program will be jointly operated by the CMHS long-term care and residential placement teams. CMHS is asking for a total of 1.1 million dollars for 3 years from the State of which almost $400,000 will be used in the first year.

Mr. Stinson: I want to say thank you to Helynna and Rich for putting together our Annual Report.

Ms. Leung: We had a very good meeting of the Media Strategies Committee last week, including Augusta and Sandy. Idell was there for a few minutes before going to a hearing on the budget. Right after the Reception we'll send out press releases and Annual Reports to about 100 media outlets.

PUBLIC COMMENT

Mr. Kalman: We have in the city at least 6 or 7 support groups related to mental health, why don't we invite them the Mental Health Board meetings?

Ms. Brooke: We do invite them; they're on our mailing list.

Mr. Kalman: I would like you to make more outreach.

Ms. Brooke: I make a lot of calls to Renee who is the President of NAMI. What I hear is that Alliance members are very involved with the Alliance.

Mr. Kalman: I would like to see someone from the Mental Health Board participating in the NAMI meetings. There's a disconnect the way I see it.

Ms. Wang: I've attended NAMI meetings pretty regularly over the last couple years.

Emeric: The Alliance brings very good speakers. It's very instructive for everybody to come to these seminars. What I would like to see is some minutes from sister mental health boards of other counties.

The discussion was ended at 7:40 p.m.

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SAN FRANCISCO MENTAL HEALTH BOARD

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MEETING OF THE MENTAL HEALTH BOARD

Wednesday, June 12, 2002
1380 Howard, Room 537
6:30 p.m.

AGENDA

Public comments will be taken for each agenda item.

1.0 CALL TO ORDER AND CONSENT CALENDAR (10 minutes)
For discussion and proposed action

1.1 Call to Order and Announcements from the Chair

1.2 Consent Calendar (Attachment A)

1.2.a PROPOSED ACTION: Be it resolved that the minutes of the Mental Health Board meeting of April 10, 2002, be approved as submitted.

1.2.b PROPOSED ACTION: Be it resolved that the Mental Health Board grants leaves of absence for the meeting of May 8, 2002, to the following members: Carol Knight, Sandy Yuen, Bridgett Brown, Kate Walker

1.2c PROPOSED ACTION: Be it resolved that the Mental Health Board grants leaves of absence for the meeting of June 12, 2002, to the following members: Toye Moses

2.0 PRESENTATION: Presentation by Carolyn Kaufman, Director of Mobile Crisis and about the Proposed 24 Hour Drop In Center.

3.0 DIRECTORS REPORTS (30 minutes)
For discussion

3.1 Report from the Director of Community Mental Health Services
A report on the activities and operations of Community Mental Health Services, including budget, planning, policy, and programs and services.

3.2 Report from the Executive Director of the Mental Health Board
A report including updates and announcements regarding the activities and operations of the Board.

4.0 MENTAL HEALTH BOARD COMMITTEES (20 minutes)

For discussion and proposed action

4.1 Report of the Chair of the Board and Executive Committee

The chair will report discussions and actions of Executive Committee. Committee chairs will describe the two Ad Hoc Committees and seek participants.

4.1 a PROPOSED ACTION: Be it resolved that the Mental Health Board urges the Board of Supervisors of the City and County of San Francisco fund the Mobile Crisis Team for 24 hours per day, seven days per week.

4.1 b PROPOSED ACTION: Be it resolved that the Mental Health Board urges the City and County of San Francisco to take an official position of strong support for full funding for the Children's System of Care.

4.1.c PROPOSED ACTION: Be it resolved that the Mental Health Board certifies that it has reviewed the annual PATH grant which will be for $191,347 for 2002/03.

4.2 State Liaison

A report on developments regarding mental health services, policy, and funding at the state level, including the California legislature, the State Department of Mental Health, and other statewide advocacy or policy organizations.

5.0 PUBLIC COMMENT (10 minutes)

This is an opportunity for members of the public to address the Mental Health Board on items of interest to the public that are within the subject matter jurisdiction of the Mental Health Board. Additionally, public comments will be taken for each agenda item.

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MENTAL HEALTH BOARD
ATTACHMENT A
June 12, 2002

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MENTAL HEALTH BOARD
ATTACHMENT B
June 12, 2002

PROPOSED RESOLUTION (MHB-2002-xx): TO EXPAND THE MOBILE CRISIS TREATMENT TEAM TO 24 HOURS A DAY, 7 DAYS A WEEK

WHEREAS, the Mobile Crisis Treatment Team, which is a program of Community Mental Health Services in the Department of Public Health, has exceeded all expectations since 1995 when it was founded, and

WHEREAS, Mobile Crisis is a key element in the overall cost-effectiveness strategy of Community Mental Health Services, and

WHEREAS, Mobile Crisis provides crisis intervention in such a way that it reduces the need for using the most expensive services, such as Psychiatric Emergency Services or the psychiatric inpatient wards at San Francisco General Hospital, and

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WHEREAS, the San Francisco Police Department is a strong supporter of Mobile Crisis, frequently calls upon Mobile Crisis, and has a close working relationship with Mobile Crisis, saving the police department significant costs in terms of officer time, and freeing up officers for doing other police duties which should be their focus, and

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MENTAL HEALTH BOARD
ATTACHMENT C
June 12, 2002

PROPOSED RESOLUTION (MHB-2002-xx): REQUESTING THAT THE CITY AND COUNTY OF SAN FRANCISCO SUPPORT FULL FUNDING FOR THE CHILDREN'S SYSTEM OF CARE

WHEREAS, Governor Gray Davis, in his May budget revision, eliminated all funding for the Children's System of Care, and

WHEREAS, more than 1 million children will experience an emotional or behavioral disorder this year according to the Little Hoover Commission report *Young Hearts and Minds*, and

WHEREAS, more than 600,000 of these children will not receive adequate treatment, according to the same report, and

WHEREAS, unaddressed mental health needs result in increased school failure, juvenile justice costs, and residential and state hospital costs, and

WHEREAS, evaluations show that systems of care reduce rates of reinstitutionalization after discharge from residential settings, reduce out-of-state placements of children, and improve other individual outcomes, such as the number of behavior problems and satisfaction with services, according to *Mental Health: A Report of the Surgeon General*, and

WHEREAS, a total of just over $159 million has been spent on the Children's System of Care implementation in California over the past 15 years, while the total savings from reductions in foster care placements is $645 million, according to *California Children's System of Care, 2001 Evaluation Report*, and

WHEREAS, an essential part of the Children's System of Care is partnership between parents or guardians and service providers to insure the provision of individualized care that builds on child and family strengths and promotes the development of competencies and social support networks, now therefore,

BE IT RESOLVED, that the Mental Health Board urges the City and County of San Francisco to take an official position of strong support for full funding for the Children's System of Care, to instruct the City's lobbyist in Sacramento to work for the reinstatement of those funds, and to encourage San Francisco's state legislative delegation to do the same.

SAN FRANCISCO MENTAL HEALTH BOARD

1380 Howard Street, Suite 510
San Francisco, CA 94103
(415) 255-3474 fax: 255-3760
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MENTAL HEALTH BOARD
ATTACHMENT D
June 12, 2002

REVIEW OF THE PATH GRANT

The Mental Health Board is required every year to review the renewal of the Community Mental Health Services grant from the Federal Projects for Assistance in Transition from Homelessness (PATH).

PROPOSED RESOLUTION

Be it resolved that the Mental Health Board send a letter to Jo Ruffin, Director, Community Mental Health Services, stating that the Board has reviewed the CMHS renewal the proposal for the 2002/03 grant from the federal Projects for Assistance in Transition from Homelessness (PATH) with an increase for fiscal year 2002/03 of $22,951 for a total of $191,347, and that the Board gives its full approval and support to this grant.

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MINUTES
Mental Health Board
Wednesday, June 12, 2002
1380 Howard Street, Room 537
San Francisco, CA 94103
6:30 p.m.

BOARD MEMBERS PRESENT: Ted Stinson (Chair); Bridgett Brown; Augusta Del Zotto, Ph.D.; Bob Douglas; Carol Knight; chance martin; Rick Nizzardini; Rose Chung for Supervisor Aaron Peskin; Carol Shaffer, R.N., N.P., M.S.N., Kate Walker; Idell Wilson.

BOARD MEMBERS ON LEAVE: Robyn Buckins; Andrea Leung, L.C.S.W., A.C.S.W.; Toye Moses, Ph.D., M.P.H.; Sandy Yuen.

BOARD MEMBERS ABSENT: Dennis Yun.

PRESENTERS: Carolyn Kaufman, Program Director, Mobile Crisis Treatment Team

OTHERS PRESENT: Jo Ruffin (Director of Community Mental Health Services); Phoebe Kwok; Helynna Brooke (MHB Executive Director); Rich Snowdon (MHB Administrator)

1.0 CALL TO ORDER AND CONSENT CALENDAR
The meeting was called to order at 6:36 p.m. by Ted Stinson, Chair.

1.1 Call to Order and Announcements from the Chair
Mr. Stinson: We have two new Board members this evening, appointed by the Rules Committee and approved by the Board of Supervisors. Dorothy Shaffer has been appointed to a Family Member Seat. Rick Nizzardini has been appointed to a Mental Health Professional Seat. I'd like to ask them to introduce themselves.

Ms. Shaffer: I'm here as a Family Member and I am a parent. I look forward to continuing my advocacy for children, especially around mental health issues. At the hearing, the Supervisors noted the diversity and number of candidates for Mental Health Board seats. The success of Helynna's recruitment was obvious. There were such good candidates, it was too bad they could not choose everybody.

Mr. Nizzardini: I'm really excited to be part of the Board. I was a practicing attorney in Washington, D.C., before going to Smith College in social work. I'm now working at Glide Health Clinic, which is a federal health facility. I provide direct services as much as I do grant writing and coordinating. But I think a lot about the bigger issues. I like the balance of doing one-on-one therapy with a homeless person in the Tenderloin dealing with mental health and substance abuse issues, and then coming here to deal with policy.

Mr. Stinson: We have just one more seat to fill to bring us to our full compliment of 17. For those of you who went through the transition period earlier this year, thank you. It's great to be back to full strength again, particularly with such strong people on the Board. I'm really excited about all the strengths people bring to the Board.

1.2 Consent Calendar

1.2.a **RESOLUTION (MHB-2002-16): Be it resolved that the minutes of the Mental Health Board meeting of April 10, 2002, be approved as submitted.**

1.2.b **RESOLUTION:(MHB-2002-17): Be it resolved that the Mental Health Board grants leaves of absence for the meeting of May 8, 2002, to the following members: Bridgett Brown, Carol Knight, Kate Walker, Sandy Yuen.**

1.2.c **RESOLUTION (MHB-2002-18): Be it resolved that the Mental Health Board grants leaves of absence for the meeting of June 12, 2002, to the following members: Toye Moses; Kate Walker, Sandy Yuen, Andrea Leung.**

2.0 PRESENTATION: Carolyn Kaufman, Director, Mobile Crisis Treatment Team
Mr. Stinson: For those of you new to the Board, one of the issues we've been focusing on is the budget, both for the City and the State. We've used this period of transition as an opportunity to focus in on the proposed cuts. We're looking at how we can make sure the needs of consumers and family members are taken into consideration by the decision makers.

Our presentation tonight is about the Mobile Crisis Treatment Team.

Carolyn Kaufman, the Director of Mobile Crisis, has worked in various capacities in the health care system since 1972. She received her BS in Nursing from San Diego State University in 1978 and MA in Clinical Psychology from Sierra University in 1986. She has worked in emergency rooms, intensive care and coronary care units, and medical/surgical units. She has also worked in drug and alcohol programs with adolescents and adults. She is currently the Program Director of the Mobile Crisis Treatment Team. She has been involved in seminars both nationally and internationally on the topic of mobile crisis intervention strategies. When not working or on-call, Carolyn cleverly manages to avoid crises in Sonoma County where she grows roses and is the personal staff to two cats.

Ms. Ruffin: Mobile Crisis is one of our key programs to help prevent people from having to go to the more expensive institutional services.

Ms. Kaufman then made a presentation as follows using slides on the overhead projector: We are not a 24-hour program, however, we'd like to become one. Mobile

Crisis is made up of a diverse multi-disciplinary staff that provides psychiatric crisis intervention services for adult residents of San Francisco. We start answering phones as early as 8:30 a.m. Our scheduled hours are:

365 days a year
Monday through Friday: 11 a.m. to 11 p.m. (last field visit at 10 p.m.)
Weekends and holidays: 12 noon to 8 p.m. (last field visit at 7 p.m.)
415-355-8300

The services we provide include:
Emergency crisis intervention services conducted in the field.
Early intervention in the field before situation escalates to crisis point.
Consultation services provided to consumers, support systems, mental health providers and shelter providers.
Assistance with linkage to outpatient mental health services.
5150 evaluation capacity and determination of appropriate level of care.
Psychiatry available for short-term medication services.
Available to all adult residents regardless of payer source.

We go out in teams. One of the first things we do is to make sure that if the person is actually having a medical emergency instead of a psychiatric emergency, we get them to medical help.

Family members might think they are seeing a mental health emergency, but grandma might be having a hypertensive crisis. She might be having very high blood pressure. There might be the possibility of a stroke. So the sooner we can get her to the hospital, the less permanent the damage is likely to be. That's why we have a medical person on each team.

Our psychiatrist provides medications to people if they have run out.

Mission Statement
The goal of the Mobile Crisis Treatment Team is to provide crisis intervention services and link customers with the least restrictive level of care that is culturally competent and effective. All providers involved in the consumer's plan of care are invited to participate in the crisis intervention.

If we are going out on a call to someone who is already part of our system, then we want the case manager to come with us, because that person is the expert on the client. We want to involve anyone in the support system we can, because they can be of help.

Personnel Requirements
Multicultural—reflect population served
Multi-disciplinary
High tolerance for inappropriate behaviors
Openness to working through counter transference issues in supervision.
Flexibility—triage—start out on one destination and reassigned to another situation—chance encounter with person wandering through traffic, this becomes priority one situation.

Ability to maneuver through outpatient system in the role of client advocate.

Everyone on our staff has had between five and ten years of psychiatric emergency experience. The most important thing in this work is to be respectful. Our staff have to have a high tolerance for inappropriate behavior. They need to have a lot of flexibility, and the ability to triage. They need to have the ability to maneuver through the outpatient system. It can be confusing to consumers. If we are linking people to a service, we try to make sure they make it to their first appointment at the clinic, so we can introduce them to the person who's going to be working with them and provide an effective transition.

We have staff who speak Spanish, Cantonese, Russian, Mandarin, and Czech. If we're going out on a call and need a language none of our available staff speaks, then we call one of our clinics to get someone to go out with us. Bilingual people who are under stress, are often thinking in their primary language, and we want to make sure we are responding to cultural issues.

Services

Our total requests for services between 8/1/96 and 12/31/01 were 11,714. Our phone screens cover:

Consultation
Supervision
Heads up calls—someone who may come in over the weekend, etc.
Families searching for missing member with mental health issue.
Assist clients and providers in making linkages.
There can be multiple phone screens on one person.
All phone calls are documented.
Staff presents phone screen to team on duty and Officer of the Day, Program Director and/or Medical Director makes decision regarding appropriateness of field visit.

Referral sources: (In order most to least)

1. Family/Support System/Neighbor/Mental Health Provider.
2. Self
3. Residential
4. San Francisco Police Department
5. Tom Waddell, other medical clinics, private practitioner, hospital ER, Kaiser, Acute Diversion Unit, shelter, MacMillan Drop-in, Alcohol/drug treatment program, Mobile Outreach Support Team, Westside Crisis, HIV crisis, ACCESS, Geriatric crisis, other

Reason service is requested:

1. increasing psychotic disorganization
2. increased mania
3. hostile and threatening to others
4. homicidal ideation
5. suicidal ideation/threat to hurt self
6. severe depression
7. severely or gravely disabled

8. acute anxiety
9. multiple stressors overwhelm client
10. medication non-compliance
11. medical treatment non-compliance
12. alcohol and/or drug use
13. seeking prescription for medication

Total field visits, from 8/96 through 12/01, including follow-up visits and medication linkage: 4,463.

5150 evaluations: 8/96 through 12/01: 3,586. Met the criteria: 1,730. Did not meet the criteria: 1,856. Assistance required from SFPD: 836.

Disposition of 5150 clients: (most to least)
PES—agitated or combative
Private hospitals—St. Luke's, St. Francis, St. Mary's (no longer admits adults)

Disposition of clients who do not meet 5150 criteria:
Referrals of family members to NAMI, culturally sensitive clinic, sibling support groups, focus groups, etc.
Assisting client with call to ACCESS.
Assist client in re-establishing contact with provider (phone calls and/or transport to first session)
Assist client in re-establishing contact with provider (phone calls and/or transport to first session)
Assist client with essentials until case manager can assist (food, clothing, shelter, taxi vouchers, bus tokens, etc.)
Medication linkage
Acute Diversion Unit
Alcohol and/or drug treatment
Follow-up visits as needed
Temporary shelter

Diagnoses of Mobile Crisis clients (most to least)
Psychiatric disorder NOS (Not Otherwise Specified)—usually overlay of recent substance use that complicates picture.
Depression
Schizophrenia
Bipolar disorder
Adjustment disorder
Anxiety disorders
Substance abuse disorders

More than half of the Mobile Crisis clients have a co-existing substance abuse disorder, or dual diagnosis.

Member of the public: I have had access to Mobile Crisis services. It's far better than the police. The police are well meaning, but they tend to be blockheads, they're muscle men is what they are. They are not attuned to the needs of someone having a psychiatric breakdown. I've called in the evening when I've needed assistance and felt bad off and needed help. Sometimes when you're in crisis, talking to someone can be just as effective as taking medications.

Value added duties of Mobile Crisis

We have the ability to deploy teams for Critical Incident Stress Debriefings into the community on short notice. As part of the Emergency Response Disaster Plan, Mobile Crisis provides staff during emergencies and disasters. Staff can assist Red Cross in dealing with mental health issues in temporary shelters.

We provide critical incident stress debriefings. If there is a shooting, for instance, or if a staff person in a private company is suddenly killed, we go in and do a critical incident debriefing. On September 11, we went to the Marriott Hotel where there were over 600 stranded New Yorkers who were very concerned about loved ones back in New York. During the El Nino rains, staff assisted at shelters helping the Red Cross.

During incidents such as hotel fires, the Medical Director provides replacement medications.

How referrals to Mobile Crisis are made

Priority 1—Emergency/Life Threatening
Danger to Self/Danger to Others. Clearly an emergent event. Referrals from 911 and/or SFPD.
Response time: 2 hours (90% less than 1 hour)

Priority 2—Urgent
Grave disability especially when medical and/or acute symptoms present.
Response time: 4 hours (90% less than 2 hours)

Priority 3—Routine
Follow-up on seriously and persistently mentally ill client whose condition is at baseline or who is beginning to decompensate.
Response time: 24 hours

Priority 4
Follow-up visits to check on response to medications and/or meet with numerous other providers and the client in the community.
Response time: variable.

When to consult with Mobile Crisis

When in doubt, consult. Call 355-8300.

Client is suicidal/homicidal and has a firearm. (Call SFPD and MCTT.)
Client has a discrete suicide plan and the means to carry it out. If the client has already overdosed. (Call 911.)
Client has command hallucinations to kill self or injure others.
Client is suicidal, has no support system and has just experienced a loss, such as a death, or has learned about having a chronic illness, etc.

Client has a need to harm self due to paranoia and uses substances.
Client has history of becoming psychotic and making very poor judgments.
Client cannot make reality-based statements about how food, shelter, and clothing will be provided.
Client has many complicated medical and psychiatric issues and it is unclear what should be addressed first.

Dr. Del Zotto: What if there are kids present? Ms. Kaufman: Normally there are relatives present and they will volunteer to take care of the children. The only time when this generally doesn't happen is where Child Protective Services (CPS) has found neglect, and they will take the child into custody. Sometimes we come to a situation and find child neglect and then call CPS.

One reason we have two people on our Mobile Crisis teams is that one of us is focusing on the identified client and the other is talking with everyone else present.

Ms. Ruffin: CMHS also has a Comprehensive Child Crisis Service and it is also mobile. They go out to the child or teenager in crisis.

Ms. Kaufman: We tell family members about the local chapter of the National Alliance for the Mentally Ill (NAMI). Especially if this is a first incident of decompensation, the family members will need support. They may not understand what's happening and they may feel embarrassed.

If we are taking someone to an Acute Diversion Unit, we have a book with photos of the programs, so the family members can see what the place looks like and they will know where their loved one is going.

Sometimes the people we connect with are just plain hungry, so we'll take the person out to lunch, just like friends go out to coffee together. If the person wants medication, we arrange for the psychiatrist to show up during the lunch. The person can sign a consent form and start medication then and there.

A lot of people want medication, but they don't want to be in the hospital. We offer the opportunity for people to take medication without having to go into the hospital. We help people get into alcohol and drug treatment.

Mr. Nizzardini: What's your determination about when you will transfer someone or not? What amount of time does it take to get to a call?

Ms. Kaufman: Both team members caucus with each other at some point about transport. If either member of the team has a gut feeling that transport is not going to work, then we call the police. If there is an unstable medical condition, then we call an ambulance.

How soon do we get there? Although we are an emergency service, we only have two cars and a van. Sometimes one of them is in the shop. Our guidelines say that we have two hours to get to a priority one call. That's because we might be out at a crisis on the other side of the city when the next call comes in. But in 90% of the cases we're there within 30 minutes. We let the person making the referral know our estimated time of arrival. If it will be a while, we may ask the police to watch the person in the meantime.

An ill-timed psychiatric hospitalization can make the person less likely to accept help in the future, so we want to work with the person on what they want.

Mr. Douglas: Do the police ever refer calls to you? Like suicide thoughts. or depression.
Ms. Kaufman: Yes, officers call us directly about people they want us to come interview. Sometimes 911 calls us to go to talk to someone.

Mr. Stinson: What sort of outreach do you do to let people know about your services?
Ms. Kaufman: Last year I did 118 hours of community outreach. I also have my team go out and do outreach to get the word out. With police officers outreach has been very effective. They will give out a flyer to families.

3.0 DIRECTORS REPORTS

3.1 Report from the Director of Community Mental Health Services

Ms. Ruffin reported as follows: For those of you who don't know me, I'm Jo Ruffin, Director of Community Mental Health Services, which is part of the Department of Public Health. I've had two hip replacement surgeries. About three months ago, I took a fall and dislocated my new hip and broke my arm. This is my first week back. I'm looking forward to meeting those of you I don't already know.

I've been working for CMHS for 35 years. I'm a social worker by training and have worked in all aspects of mental health during my career. I started out in the jail psychiatric clinic. That program is now separate from CMHS. Then I worked on inpatient units, in day treatment programs, outpatient clinics, and did crisis home visiting. Then for 25 years I was running the geriatric system in CMHS.

I've been Director of CMHS for the past seven years. We've gone through a lot of challenges and changes. This includes developing the San Francisco Mental Health Plan. The State used to run a Medi-Cal fee for service system, which meant that people could choose to go to a private doctor. But about six years ago the State turned all of that over to the county systems. So we've created what's known as the Mental Health Plan, which covers all people who have Medi-Cal.

San Francisco decided to provide a plan that covers non-Medi-Cal people who are indigent. We call it the Single Standard of Care. If you are a poor working person who has no coverage, you can get services from our system. In a lot of counties that doesn't happen.

One of the ways we try to maintain all these services, is to manage the high-end, the most expensive part of our system, which means inpatient and long-term care, services. We try to shift savings from that area to community-based care. We're always trying to maximize the community services and the alternatives to hospitalization.

We serve all ages, cultural groups, and ethnic groups. We're required to provide all our materials in English, Cantonese, and Spanish. We make a special effort with regard to our Russian population.

In relation to the budget cuts, we were preparing to face about $8 million in cuts. But because revenue collection is tied to many of these programs, we would have had to cut another $4 million in revenues for total of about $12 million.

The Mayor's office has now made the cuts. The cut to mental health is not nearly as large as $12 million. What has been cut is $500,000, which is targeted to come out of high-end services. This includes a $200,000 cut to our inpatient contracts with St. Mary's, St. Francis, and St. Luke's. There's a cut of $200,000 to our private provider network. A cut of $100,000 is taken out of our locked facility budget. This is much better than a $12 million cut, but it is still a serious reduction. We are allowed to move money around within those cuts.

That's on the county level. Mostly mental health money does not come from the state anymore. About ten years ago, most state mental health money was moved to realignment, to tie it to sales tax revenue and the Vehicle Licensing Fee for the counties. This helps protect us from state budget cuts.

The Governor's Office has proposed cutting all of the funds for the Children's System of Care (CSOC). For San Francisco this is about $1.2 million. There is quite a bit of lobbying with the State Assembly to have that money restored. I believe Senator Burton was going to meet with the Governor's Office today to see if that funding can be restored.

It's a very important time right now to try to get some communication to the Governor's Office about the CSOC funding.

In San Francisco, we had one of the highest rates of foster care of anywhere in the California. Since implementation of CSOC, the foster placement rate is dropping.

We've wanted to make Mobile Crisis a 24-hour program for quite some time. But because of budget cuts it looks like we will not be able to do that. In the meantime, the Coalition on Homelessness and the People's Budget process have identified the need for a 24/7 drop in center that could work with Mobile Crisis and the shelters, and give a place for people to call.

I felt it was a very good planning process for the drop-in center. People came together around the vision. The cost would be about $1.2 million. This is much more than the $100,000 the Board of Supervisors gave us as seed money. And that was just one time money. So we are back to square one in terms of the funding for the drop-in center. We didn't feel like we could cut something else in order to fund the drop-in center. So it is an unmet need.

Lastly, I want to congratulate you on getting your Board seats filled. This is a wonderful Board and very productive, with a great reputation. Congratulations on the work you did with the State Department of Mental Health and Dr. Stephen Mayberg.

Mr. Douglas: Someone told me that they are seeing their clinician for half an hour when they used to see them for 50 minutes. Is that a new policy? Ms. Ruffin: It's up to the clinician. We don't set any limits.

Mr. Douglas: On the drop-in center, is that something that might be funded initially by a foundation. Ms. Ruffin: I think there is some possibility of looking for grant funds and I'm certainly willing to do that.

Ms. Brown: Is it too late to advocate for restoring the cuts? Ms. Ruffin: The budget is now going to the Board of Supervisors. So it's not too late to advocate.

Ms. Chung: You can look at the calendar on the City website and see when your department is going to be heard.

Ms. Shaffer: We're not even seeing all the children who need help, so it's terrible to cut the CSOC.

The Director's written report was distributed:

Budget Update. The Board of Supervisors' Budget Analyst Office is currently in the process of reviewing the Department's budget submission. The goal of the Budget Analyst Office is to identify potential reductions, which are often reallocated by the Board to fund various initiatives. The first hearing before the Board will be on June 19th and the final hearing will be on June 26. The Departmental budget includes a reduction of $500k to CMHS which is divided between the budgets for private fee for service hospitals, IMDs and the private provider network. Additionally, 12.15 vacant positions will be reduced. The budget does not include a contractor COLA. However, the budget submission does include funding to address several shortfalls within CMHS, which will be addressed through an increase in Federal MediCal revenues. Examples include permanent funding to keep the Crisis Resolution Team operating, and the annualization of the Broderick residential care facility.

Disposal of Sharps and Pharmaceutical Waste Containers. CMHS implemented a new service agreement starting in May for the disposal of sharps and pharmaceutical waste at CMHS clinics and affiliated sites. Previously, clinics were required to package the filled containers and mail them back to the vendor for disposal. Under the new program, the vendor (Stericycle, Inc.) will pick up both sharps and pharmaceutical waste containers at each site every three to six months, depending on the amount generated. The program is much more convenient for the providers and is budget neutral.

San Francisco Police Academy Training for CMHS Staff. On Thursday, May 22, 2002, nineteen CMHS administrators and staff attended the first day-long training from the San Francisco Regional Police Academy staff. The purpose of the training was to improve the effectiveness of the working relationship between CMHS staff and police officers by increasing the knowledge and understanding of CMHS staff about police procedures and tactics. Both the SFPD and CMHS view this training as a companion training to the 40-hour Police Crisis Intervention Trainings that are conducted by DPH staff for SFPD officers. The evaluations from the participants in this first training were uniformly very positive and staff commented in particular on how well organized the training was and on the quality of the instructors. The participants were clear that the training increased their empathy for the job the police must do and increased their understanding of police procedures. This training promises to be another positive component in helping mental health staff and police officers work together more effectively. The tentative plan is to repeat this training about twice a year.

Consumer Fair. CMHS Cultural Competence and Consumer Relations held its first annual Mental Health Fair at the main Library on May 31. It was held to commemorate May as mental health awareness month. The fair was coordinated, planned and held by consumers for consumers. There were 15 organizations; some of the participants were the STEP, Chinese Family Alliance, and Oasis. Consumers manned the booths, and distributed literature and information. There were performances of celebratory expression in poetry and song. The Fair took place from 1 PM to 5 PM. Approximately 100 people dropped by the booth set up and refreshments were served. The event was a huge success.

3.2 Report from the Executive Director of the Mental Health Board

Ms. Brooke: I want to congratulate everyone on the Reception. It was fantastic. I think we showed Dr. Stephen Mayberg what great mental health services we have. These kinds of things are really, really important. He said that by meeting clients and outreach workers, he'll be able to advocate much more strongly with legislators in Sacramento.

The Media and Budget Committees have both met. The Media Committee sent out a press release and Annual Report to 100 media outlets. We got a call from KNBR and were interviewed for a program distributed to four radio stations.

Mr. Stinson: In terms of following up on the budget, I feel particularly proud of the impact the Board has had over the past several months. We have made a difference.

4.0 MENTAL HEALTH BOARD COMMITTEES

4.1 Report of the Chair of the Board and Executive Committee.

Mr. Stinson: We have taken this period of transition for the Board and have re-focused our committee work on the budget. Now it's time to reapproach the way we want to do committees. For those of you who are new, we ask in addition to attending full Board meetings that you attend one committee meeting each month. I'd encourage you to think about the one or two issues most important to you. And ideally we'd ask the committees to take on those issues.

4.1.a **RESOLUTION (MHB-2002-19):**
TO EXPAND THE MOBILE CRISIS TREATMENT TEAM TO 24 HOURS A DAY, 7 DAYS A WEEK

WHEREAS, the Mobile Crisis Treatment Team, which is a program of Community Mental Health Services in the Department of Public Health, has exceeded all expectations since 1995 when it was founded, and

WHEREAS, Mobile Crisis is a key element in the overall cost-effectiveness strategy of Community Mental Health Services, and

WHEREAS, Mobile Crisis provides crisis intervention in such a way that it reduces the need for using the most expensive services, such as Psychiatric Emergency Services or the psychiatric inpatient wards at San Francisco General Hospital, and

WHEREAS, Mobile Crisis provides early intervention in such a way that the number of mental health crises in San Francisco are significantly reduced, and

WHEREAS, the San Francisco Police Department is a strong supporter of Mobile Crisis, frequently calls upon Mobile Crisis, and has a close working relationship with Mobile Crisis, saving the police department significant costs in terms of officer time, and freeing up officers for doing other police duties which should be their focus, and

WHEREAS, Mobile Crisis has been a godsend to the families of the seriously mentally ill, and is a service family members can call upon when they see a loved one showing the warning signs of distress or decompensation, and

WHEREAS, the staff of Mobile Crisis have been honored by the Mental Health Board for having a deep commitment to their mission and their work, and

WHEREAS, in challenging financial times, it is more important than ever for the City to employ the most cost-effective strategies possible in delivering public health services, now, therefore,

BE IT RESOLVED that the Mental Health Board recommends in the strongest possible terms to the Health Commission, the Board of Supervisors, and the Mayor that the Mobile Crisis Treatment Team be funded at a level which allows it to operate 24 hours a day, seven days a week. (Passed.)

4.1.b RESOLUTION (MHB-2002-20): REQUESTING THAT THE CITY AND COUNTY OF SAN FRANCISCO SUPPORT FULL FUNDING FOR THE CHILDREN'S SYSTEM OF CARE

WHEREAS, Governor Gray Davis, in his May budget revision, eliminated all funding for the Children's System of Care, and

WHEREAS, more than 1 million children will experience an emotional or behavioral disorder this year according to the Little Hoover Commission report *Young Hearts and Minds*, and

WHEREAS, more than 600,000 of these children will not receive adequate treatment, according to the same report, and

WHEREAS, unaddressed mental health needs result in increased school failure, juvenile justice costs, and residential and state hospital costs, and

WHEREAS, evaluations show that systems of care reduce rates of re-institutionalization after discharge from residential settings, reduce out-of-state placements of children, and improve other individual outcomes, such as the number of behavior problems and satisfaction with services, according to *Mental Health: A Report of the Surgeon General*, and

WHEREAS, a total of just over $159 million has been spent on the Children's System of Care implementation in California over the past 15 years, while the total savings from reductions in foster care placements is $645 million, according to *California Children's System of Care, 2001 Evaluation Report*, and

WHEREAS, an essential part of the Children's System of Care is partnership between parents or guardians and service providers to insure the provision of individualized care that builds on child and family strengths and promotes the development of competencies and social support networks, now therefore,

BE IT RESOLVED, that the Mental Health Board urges the City and County of San Francisco to take an official position of strong support for full funding for the Children's System of Care, to instruct the City's lobbyist in Sacramento to work for the reinstatement of those funds, and to encourage San Francisco's state legislative delegation to do the same. (Passed.)

4.1.c **RESOLUTION (MHB-2002-21) IN SUPPORT OF THE ANNUAL PATH GRANT.**

Be it resolved that the Mental Health Board send a letter to Jo Ruffin, Director, Community Mental Health Services, stating that the Board has reviewed the CMHS renewal the proposal for the 2002/03 grant from the federal Projects for Assistance in Transition from Homelessness (PATH) with an increase for fiscal year 2002/03 of $22,951 for a total of $191,347, and that the Board gives its full approval and support to this grant. (Passed.)

4.2 State Liaison

No report.

5.0 PUBLIC COMMENT

Member of the public: I work in the financial district and see a lot of people who park themselves on corners on a daily basis. It's very distracting to tourists and others. Is there anything that can be done? They are not hurting anyone or hurting themselves, but is there anything can be done?

Mr. Stinson: There are lots of different perspectives on that, and lots of good ideas for helping people, but they do not come cheap.

Mr. Martin: Sitting on the street and panhandling are protected by the first amendment.

Mr. Martin: I urge you to support affordable housing. We only have shelter space for about ten percent of the number of homeless people the City claims on their federal applications. And there may be many more homeless people than that.

Member of the public: You seem to be angry about this.

Dr. Del Zotto: I live on Union Street. On Friday night lots of people from the financial district come out to my street and get drunk and are very disturbing.

Mr. Stinson: This is a very important question which our city needs to address. This Board is not the venue for a general discussion on homelessness. We can have discussions on issues of mental health and homelessness.

Ms, Ruffin: Homelessness in general is not the purview of the mental health system or the Mental Health Board. But if people are displaying signs of mental illness, then Mobile Crisis can be called. But if the question is the problem of people sitting on the street disrupting the flow of traffic, that's not a mental health issue.

There being no further business, the meeting was adjourned at 8:16 p.m.

SAN FRANCISCO MENTAL HEALTH BOARD

1380 Howard Street, Suite 510
San Francisco, CA 94103
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MEETING OF THE MENTAL HEALTH BOARD

Wednesday, July 10, 2002
1380 Howard, Room 537
6:30 p.m.

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AGENDA

Public comments will be taken for each agenda item.

1.0 CALL TO ORDER AND CONSENT CALENDAR (10 minutes)

For discussion and proposed action

1.1 Call to Order and Announcements from the Chair

1.2 Consent Calendar (Attachment A)

1.2.a PROPOSED ACTION: Be it resolved that the minutes of the Mental Health Board meeting of June 12, 2002, be approved as submitted.

1.2.b PROPOSED ACTION: Be it resolved that the Mental Health Board grants leaves of absence for the meeting of July 10, 2002, to the following members: Dennis Yun

1.2 c PROPOSED ACTION: Be it resolved that the Mental Health Board cancels its regularly scheduled meeting on August 14, 2002 due to summer vacations.

2.0 PRESENTATION: Presentation of two Children's Services programs (50 min.)

Shelley Frank, Ph.D., Executive Director, Family Mosaic Project
Fawn Downs, LCSW, Assistant Director of Comprehensive Child Crisis Services

3.0 DIRECTORS REPORTS (30 minutes)

For discussion

3.1 Report from the Director of Community Mental Health Services
A report on the activities and operations of Community Mental Health Services, including budget, planning, policy, and programs and services.

3.2 Report from the Executive Director of the Mental Health Board
A report including updates and announcements regarding the activities and operations of the Board.

4.0 MENTAL HEALTH BOARD COMMITTEES (20 minutes)

For discussion and proposed action

4.1 Report of the Chair of the Board and Executive Committee

The chair will report discussions and actions of Executive Committee. Organization of committees will be discussed. Board member mentorship will also be discussed.

4.1 a PROPOSED ACTION: Be it resolved that the Mental Health Board commends Supervisor Sophie Maxwell for her role in creating a more streamlined contracting process.

5.0 PUBLIC COMMENT (10 minutes)

This is an opportunity for members of the public to address the Mental Health Board on items of interest to the public that are within the subject matter jurisdiction of the Mental Health Board. Additionally, public comments will be taken for each agenda item.

This agenda and all attachments can be viewed at: www.ci.sf.ca.us/mental_health. Attachments are also available at the Mental Health Board Office, 1380 Howard Street, Suite 510, telephone 255-3474.

DISABILITY ACCESS

1. American Sign Language interpreters and/or a sound enhancement system will be available on request. Please contact Ladonnis Elston at (415) 255-3444 (voice) or (415) 255-3449 (TTD) 5 days before the meeting. Large print copies of the agenda will be made available upon request; please call (415) 255-3474.

2. Meetings are held at 1380 Howard Street (corner of 10th Street), in Room 537. The closest accessible BART station is the Civic Center station, at the intersection of Market, Grove and Hyde Streets. The closest Muni Metro station is the Van Ness Station. Accessible MUNI lines serving the location are the 9 San Bruno, 47 Van Ness, and the 72 Haight/Noriega. For more information or updates about the current status of MUNI accessible services, call (415) 923-6142. For information about Paratransit Services call (415) 351-7000.

3. The main entrance to 1380 Howard is accessible to wheelchairs. Elevators, doorways, restrooms, and the meeting room are wheelchair accessible. Accessible curbside parking has been designated on Grace Alley which runs on the opposite side of the building from 10th Street.

4. In order to assist the City's efforts to accommodate persons with severe allergies, environmental illnesses, multiple chemical sensitivity or related disabilities, attendees at public meetings are reminded that other attendees may be sensitive to various chemical based products. Please help the City accommodate these individuals.

POLICY ON CELL PHONE, PAGERS, AND ELECTRONIC DEVICES

The ringing of and use of cell phones, pagers, and similar sound-producing electronic devices are prohibited at this meeting. Please be advised that the Chair may order the removal from the meeting room of any person(s) responsible for the ringing or use of a cell phone, pager, or other similar sound-producing electronic devices.

KNOW YOUR RIGHTS UNDER THE SUNSHINE ORDINANCE

Government's duty is to serve the public, reaching its decisions in full view of the public. Commissions, boards, councils and other agencies of the City and County exist to conduct the people's business. This ordinance assures that deliberations are conducted before the people and that City operations are open to the people's review. For more information on your rights under the Sunshine Ordinance (Chapter 67 of the San Francisco Administrative Code) or to report a violation of the ordinance, contact:

Donna Hall
Sunshine Ordinance Task Force
City Hall, Room 244
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102-4689
Telephone: (415)554-7724
Fax: 4(15) 554-5163
E-mail: Donna_Hall@ci.sf.ca.us

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To view Mental Health Board agendas and minutes, you may visit the MHB web page at: **www.ci.sf.ca.us/mental_health**. You may also go to the Government Information Center at the Main Library at Larkin and Grove in the Civic Center. You may also get copies of these documents through the MHB office at 255-3474.

Lobbyist Registration and Reporting Requirements

Individuals and entities that influence or attempt to influence local legislative or administrative action may be required by the San Francisco Lobbyist Ordinance [SF Campaign & Governmental Conduct Code 2.100] to register and report lobbying activity. For more information about the Lobbyist Ordinance, please contact the San Francisco Ethics Commission at 30 Van Ness Avenue, Suite 3900, San Francisco, CA 94102; telephone (415) 581-2300; fax (415) 581-2317; web site www.sfgov.org/ethics.

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MENTAL HEALTH BOARD
ATTACHMENT A
July 10, 2002

CONSENT CALENDAR

All items on the Consent Calendar are handled through a single vote. There will be no discussion unless a member requests it, in which case the item will be removed from Consent Calendar and discussed. Additional names may be added to the leave of absence resolution during the meeting.

1.2.a PROPOSED RESOLUTION: **Be it resolved that the minutes of the Mental Health Board meeting of June 12, 2002, be approved as submitted.**

1.2.b PROPOSED RESOLUTION: **Be it resolved that the Mental Health Board grants leaves of absence for the meeting of July 10, 2002, to the following members: Dennis Yun.**

1.2.c PROPOSED RESOLUTION: **Be it resolved that the Mental Health Board cancels its regularly scheduled meeting on August 14, 2002 due to summer vacations.**

AN OVERVIEW OF THE FAMILY MOSAIC PROJECT

Client Vignettes from Family Mosaic Case Files

14-year-old Sandy has had emotional and behavioral problems, as well as diabetes, since age three. In the year before her admission to Family Mosaic Project(FMP), she was hospitalized six times for violent and self-harmful behaviors. Two of these hospitalizations followed near-death comas associated with Sandy's repeated refusal to take her insulin. The family also has had significant problems. Sandy's mother has suffered for years with untreated depression, and she uses cocaine regularly. Her 19-year-old brother reportedly is a cocaine dealer, and has been arrested multiple times. Sandy is one of four grandchildren who are being raised by their grandmother, though she recently contacted the Department of Human Services (DHS) to have the kids placed in foster care because she was unable to manage their behavior.

In addition to receiving mental health services, Sandy also receives academic supports for a learning disability through Special Education classes. Just prior to her admission to Family Mosaic, Sandy became involved with the Juvenile Probation Department, after allegedly pistol-whipping an elderly woman just for the fun of it. She was referred for intensive care management and wraparound services by her probation officer, and subsequently was assigned an FMP Care Manager/Family Advocate to develop and coordinate a multi-disciplinary care plan with all of the above agencies and her pediatrician.

After a comprehensive assessment, the Care Manager arranged a multi-agency meeting that included Sandy, her grandmother and foster parents, the DHS caseworker, and her probation officer. The resulting Plan of Care that was coordinated by the Advocate called for individual and family therapy, a referral for shadow services, substance abuse counseling and a Transitional Youth Services referral for the brother, and mentoring and tutoring services to help Sandy improve her social and academic functioning. Finally, FMP's public health nurse was assigned to provide education and support around Sandy's diabetes, and to work with the pediatrician to monitor Sandy's medication compliance and general health condition.

Eleven-year-old Darian hadn't attended school for 6 months, and recently was diagnosed with depression. None of his three siblings were attending school either. Darian's mother was diagnosed with a terminal illness five years ago, and recently experienced a significant deterioration in her health, requiring multiple extended medical hospitalizations. The family was living in a small apartment with multiple pets, and recently had received an eviction notice from the landlord as a result of chaotic conditions in the home.

Two Family Mosaic Project Care Manager/Family Advocates worked with Darian's family to bring the animals to the SPCA, get the apartment cleaned, and negotiate with the landlord to prevent the family from being evicted. The assigned Care Manager arranged for wraparound services, including in-home family therapy, coordination with Darian's outpatient clinic therapist, tutoring, and recreational activities for all of the children. The FMP Advocate also worked closely with the health care agencies that were serving the mother, so that mental health supports could be implemented to help the family deal with her illness and impending placement of the children with relatives. Finally, FMP arranged for in-home support services such as house cleaning, grocery shopping, and meal preparation, in order to reduce the family's emotional and physical stress and improve their current quality of life.

Overview:

It is estimated that one in five children has a mental health problem, but only one-third of all children with mental health disorders receive treatment. At least one in ten children is seriously emotionally disturbed (SED), though these students may not be formally classified as such by their jurisdictional school districts. Almost half of emotionally disturbed students drop out of school between grades 9 and 12, and 20% are arrested at least once before leaving school. National data indicate that between 43% and 70% of abused and neglected children entering child welfare systems have mental health problems severe enough to require treatment. In San Francisco, these children typically have been served by five different public systems: Department of Human Services, Community Mental Health Services, Department of Public Health, Juvenile Probation Department, and the San Francisco Unified School District. Yet no agency is singularly responsible for the child, and the family often is frustrated by the frequent fragmentation of services among providers from various departments.

To address the needs of children and youth with severe emotional and behavioral problems, Family Mosaic Project was developed in 1991 to target children who are at high risk for out-of-home placement. As a result of their multiple problems, complex family structures, and often poor histories of service involvement, this population typically has been seen as highly challenging for human service organizations. The Family Mosaic Project coordinates and oversees mental health treatment for these individuals, and purchases and monitors other necessary wraparound services from a network of private providers and community-based organizations that are willing to provide extraordinary outreach in order to keep families together.

Project Goals:

The Family Mosaic Project seeks to improve the well-being of emotionally disturbed children who are at risk for out-of-home placement. We are committed to doing "whatever it takes" to keep youth out of psychiatric hospitals, juvenile detention centers, and group home placements, and to help them remain in school. Family Mosaic strives to improve the overall functioning of young clients and their families, so that they can live productive lives together in their home communities.

Funding:

The Family Mosaic Project began in 1991 as part of the national Robert Wood Johnson Foundation Mental Health Services Program for Youth. Family Mosaic currently has a capitated contract with the California Department of Health Services, with major funding through the Medi-Cal program. Thus, in order to qualify for admission into FMP, children must be residents of San Francisco and have full-scope Medi-Cal benefits. Each child enrolled in the program is allocated a monthly capitation rate, which is available as long as the child and family continue to meet target population criteria and medical necessity for intensive services intervention.

Program Overview:

Clients are referred to Family Mosaic Project from public agencies such as Children's Protective Services, as well as from private health care providers, pediatricians, parents, and teachers. An interagency placement committee, with participation by Community Mental Health, the Unified School District, Juvenile Probation, and Department of Human Services, meets weekly to assess children's eligibility for enrollment in FMP. Upon admission, each client is matched for cultural and linguistic needs with a Care Manager/Family Advocate, who conducts a comprehensive needs assessment of the child and family. This includes a full description of the child's problems; a history of developmental, familial, and social factors that may be contributing to the difficulties; a brief mental status exam, and description of any physical health needs; academic history, including Special Education needs; and identification of child and family strengths that may be utilized to address treatment needs.

Based on this Assessment, and working with the family, the FMP Advocate/Care Manager develops a "Plan of Care" that identifies specific goals in all areas of the child's life: mental health, education, physical health, recreation, and family support. It is the Advocate's responsibility to access, broker, and authorize payment for all necessary wraparound services, and to coordinate all components of the comprehensive care plan. Examples of services may include field-based individual and family therapy, day treatment, tutoring, in-home supports, mentoring, public health nursing care, psycho-education, recreational activities, and psychiatric evaluations and medication support.

Program Highlights:

The Family Mosaic Project currently serves approximately 200 families in San Francisco. Greater than half the clientele are African-American, with approximately 16% Latino/Chicano, 11% Asian-Pacific Islander, 12% Caucasian, and 7% Other. Twenty-eight percent of FMP youth are delinquent minors who have had some involvement with the juvenile justice system, and almost one-fourth receive Special Education services at school.

Outcome evaluations of Family Mosaic Project across time periods (1990-97 and 1996-2000) consistently have demonstrated the program's effectiveness in the following areas:

Psychiatric hospitalizations decreased dramatically (44%-55%), while county rates increased

Residential placements are reduced by 50% to 73%, compared to placement rates prior to FMP admission

Among offenders, the average number of crimes/youth decreased by up to 88%, with only 10% recidivism

After program costs, Family Mosaic Project nets average savings of almost four million dollars annually

FOR MORE INFORMATION: Contact Rochelle I. Frank, Ph.D., Clinical Director of Family Mosaic Project
1309 Evans Ave., SF, CA 94124. PH: (415)206-7600 FAX: (415)206-7630 EMAIL: Rochelle.Frank@sfdph.org

Community Mental Health Services - Children, Youth & Family Section (CMHS/CYF)
Sai-Ling Chan-Sew, Director

SFDPH

Sai-Ling Chan-Sew, Director

Community Mental Health Services - Children, Youth & Family Section (CMHS/CYF)

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AN OVERVIEW OF 24-HOUR INPATIENT AND CRISIS INTERVENTION TREATMENT SERVICE

Arriving from El Salvador a year prior, a 16-years old homeless Latino boy becomes a dependent of the court and is placed in a group home. After four inpatient hospitalizations (diagnoses of major depression) for impulsive, suicidal, and aggressive behavior, he is enrolled into a structured day treatment program along with outpatient therapy, shadow services and coordinated care. During the fiscal year of high use, he is persistently non-compliant with mental health interventions, runs from the group home, and becomes AWOL from day treatment. There are two further crisis interventions for suicidal gestures and a hospitalization.

A 16-year old Cambodian girl is voluntarily hospitalized (for 39 days) after crisis intervention for suicidal and homicidal ideation following disclosure during a church retreat of sexual molestation by a neighborhood boy. Her adjustment to the abuse trauma (depress, suicidal and homicidal feelings, and bulimia) is complicated by slow cognition and delayed emotional development coupled with normal adolescent physical development. She undergoes additional crisis episodes resulting in three voluntary and three involuntary inpatient hospitalization.

- *Vignettes from Higher User of Mental Health Services Data Report (April 1998)*

Any child in San Francisco is eligible to receive 24 hour evaluating crisis intervention and mental health services for psychiatric and sex abuse problems. Inpatient psychiatric services are offered when a child or adolescent needs 24-hour care and treatment for an acute psychiatric problem and is a danger to self or others. This may require a hospitalization of a child or adolescent for evaluation, testing, and acute care and stabilization. Referrals for involuntary inpatient care are made through Comprehensive Child Crisis Services. Referrals for evaluation and treatment for child or adolescent victims of sexual abuse are made to the Child Adolescent Sexual Abuse Resource Center (CASARC).

CASARC RNs and MDs provide 24-hour medical and forensic evidence collection services for children and youth who have been sexually abused. CASARC Social Workers provide mental health individual, case management and medication services for children and youth where there is either suspected or documented sexual abuse.

24-Hour Comprehensive Child Crisis Services, 3801 Third St, Suite 400, SF, CA 94124, PH: 415.970.3800, FAX: 415.970.3855.

- Comprehensive Child Crisis Services is 24-hour crisis intervention program, which provides psychiatric evaluation, consultation, home visits, short-term psychotherapy, medication evaluations and referrals to community treatment programs.

Child/Adolescent Sexual Abuse Resource Center (CASARC), San Francisco General Hospital, 996 Potrero Ave., Ward 82, Rm 239, SF, CA 94110, 415.206.8386, FAX: 415.206.6273.

- CASARC provides 24-hour emergency medical services, forensic evidence collection, and crisis intervention for child and adolescent victims of sexual abuse. CASARC also provides individual therapy for victims, consultation and referrals to community services.

FOR MORE INFORMATION: Contact Jack Rabin, LCSW, Assistant Director 24 Hour Care, PH: 415.255.3412 or FAX: 415.255.3567, Jack_Rabin@dph.sf.ca.us.

(5/26/00)

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MENTAL HEALTH BOARD
ATTACHMENT B
July 10, 2002

PROPOSED RESOLUTION (MHB-2002-xx) IN SUPPORT OF SUPERVISOR SOPHIE MAXWELL'S INITIATIVE TO STREAMLINE THE CITY'S CONTRACTING PROCESS

WHEREAS, many nonprofit agencies which provide services to the City and County of San Francisco have contracts with a number of different City departments at the same time, and

WHEREAS, these City departments require the same nonprofit agencies to provide the same information in very different formats, and

WHEREAS, this variety of formats does not add any specific value to the contracting process for the City, and

WHEREAS, the nonprofit agencies have to spend a significant amount of administrative time to comply with the differing formats, and

WHEREAS, the nonprofit agencies need to be spending their resources as much as possible on services rather than duplicative administrative work, and

WHEREAS, the San Francisco Human Services Network has asked for a standardization of the format for core information, and

WHEREAS, Supervisor Sophie Maxwell is working closely with the San Francisco Human Services Network to create effective strategies and solutions; now, therefore

BE IT RESOLVED, that the Mental Health Board expresses its gratitude to Supervisor Maxwell for her leadership in solving a long-ignored problem, for her commitment to maximizing resources spent on direct services while reducing duplicative administrative work, for boosting the morale of the nonprofit agencies which provide services to the City, and for her abiding concern for the people of San Francisco who are in need.

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UNADOPTED MINUTES
Mental Health Board
Wednesday, July 10, 2002
1380 Howard Street, Room 537
San Francisco, CA 94103
6:30 p.m.

BOARD MEMBERS PRESENT: Ted Stinson (Chair); Bridgett Brown; Robyn Buckins; Augusta Del Zotto, Ph.D.; Bob Douglas; Carol Knight; Andrea Leung, L.C.S.W., A.C.S.W.; chance martin; Toye Moses, Ph.D., M.P.H.; Rick Nizzardini, L.C.S.W., J.D.; Rose Chung for Supervisor Aaron Peskin; Dorothy Shaffer, R.N., N.P., M.S.N., Kate Walker; Idell Wilson; Sandy Yuen.

BOARD MEMBERS ON LEAVE: Dennis Yun.

BOARD MEMBERS ABSENT: none.

PRESENTERS:
Shelly Frank, Ph.D., Executive Director, Family Mosaic Project
Fawn Downs, L.C.S.W., Assistant Director, Comprehensive Child Crisis Services
Keith Hutchinson, Coordinator, Bayview School Based Services.

OTHERS PRESENT: Jo Ruffin, L.C.S.W. (Director, Community Mental Health Services); Robert Cabaj, M.D. (Director of Behavioral Health, Department of Public Health; and Designated Director, Community Mental Health Services); Phoebe Kwok; Elsie R. Cohen; Lara Argüelles (Parent); Tiffeny Jimenez (San Francisco State University); Mike Wise (San Francisco Network of Mental Health Clients); Emeric Kalman; Helynna Brooke (MHB Executive Director); Rich Snowdon (MHB Administrator)

1.0 CALL TO ORDER AND CONSENT CALENDAR

1.1 Call to Order and Announcements from the Chair
The meeting was called to order at 6:34 p.m. by Ted Stinson, Chair.

1.2 Consent Calendar

1.2.a **RESOLUTION (MHB-2002-22): Be it resolved that the minutes of the Mental Health Board meeting of June 12, 2002, be approved as submitted. (Passed.)**

1.2.b **RESOLUTION (MHB-2002-23): Be it resolved that the Mental Health Board grants leaves of absence for the meeting of July 10, 2002, to the following members: Dennis Yun. (Passed.)**

1.2.c **RESOLUTION (MHB-2002-24): Be it resolved that the Mental Health Board cancels its regularly scheduled meeting on August 14, 2002, due to summer vacations. (Passed.)**

Ms. Ruffin: For almost a year, Dr. Cabaj has been the Medical Director of Community Mental Health Services (CMHS). We've been trying to get him to the Mental Health Board meeting, but he's on the Board of the California Mental Health Directors Association which meets same night. He came back early from Sacramento to be here tonight.

Bob is both a psychiatrist and an addictionologist. During this past month, Bob was named as the new Director of Behavioral Health for the Department of Public Health (DPH). Mitch Katz , the Director of DPH, gave directions to create a behavioral health division, and to merge mental health and substance abuse services into an integrated behavioral health model.

I recently returned from surgery, having fallen and severely injured my arm. But I'm going to have to have more surgery. I just found out that my surgery is scheduled for next Thursday. I'm going to be out for a considerable amount of time. I told my doctor, "I've been thinking about retiring. Could we wait for surgery until I do?" But the doctor said no, because of the nerve damage in my arm. That prompted me to think about my own plans for the future. I will retire in January. DPH has allowed me to have the surgery while I'm still an employee.

In addition to his other duties, Bob will be the Designated Mental Health Director, and will continue to be the Mental Health Director after I retire. Other counties use this model.

By the time I retire, I will have been the Mental Health Director for seven years, which is a record. The previous record holder was Reiko True at four years. Most directors didn't make it more than two years.

By the time I retire, it will be 37 years that I have been in the Department. I started as an entry level social worker in our jail clinic in San Bruno before there was Jail Psychiatric Services.

This isn't quite the way I wanted to end my career, but its seems to me that this is the most sensible time. This is the first time a director of mental health has left that there has been a planned transition. So I'm really happy about that.

Now I'd like to ask Dr. Cabaj to introduce himself.

Dr. Cabaj: One of the exciting things about working here is working with Jo and seeing the vision she has for mental health. She has been fantastic.

Prior to coming here, I was the medical director for mental health in San Mateo County. I covered for the director there when she was away. I've been on the governing Board of the California Mental Health Directors Association, and have gotten a good sense of state issues.

I moved here to San Francisco in 1991 to start the substance abuse consult service at San Francisco General Hospital. Even though I've only been here at CMHS a year and a half, I've known the system for 12 years.

I'm excited to create the new behavioral health division. So many clients are shared between mental health and substance abuse services already. We hope it will enhance care and perhaps bring in new funding.

Dr. Moses: I want to commend you, Jo, for the time you've been here. I was on the interview panel when you were hired. We will continue praying for your speedy recovery.

Mr. Wise: Jo, after your retirement, it seems like you're going to have an aggravation void in your life. Any plans for the future?

Ms. Ruffin: I want to do some traveling. Having worked full time and been a full-time mom, I never did traveling. Been a social worker a long time, I might do something with that, but I won't be looking for anything right away.

You will all be invited to my retirement party.

Dr. Moses: Dr. Cabaj, initially it's going to be really hard to step into Jo's shoes. And especially since you'll be wearing four hats. And that's a concern for our Board, how you'll be able to handle all of that.

Dr. Cabaj: I'll be meeting with Mitch Katz this week. I'll need to refill or re-create the medical director position. I plan to continue hiring the doctors for the system and to keep them involved and on staff, but many other tasks I want to pass on to someone else.

As Director of Behavioral Health, I will have Jorge Partida, as Deputy Director of Behavioral Health, and he will be in charge of Substance Abuse Services. We still have some open positions, and we will be creating some new deputy directors along the way.

Dr. Moses: We also want to encourage you to think about diversity as you fill new positions.

Dr. Cabaj: For a number of years I was the Chair of the Committee of Representatives of Minority /Underrepresented Groups of the American Psychiatric Association, so I'm an advocate for diversity.

2.0 PRESENTATION: Presentation of Three Children's Services Programs

Bayview School Based Services
Mr. Hutchinson: I work through Southeast Mental Health, but I'm mostly out in the field. I work at six elementary schools: Dr. Charles Drew, Gloria R. Davis, Malcolm X, Paul Revere, Dr. G. W. Carver, and Starr King.

These are schools where children are having a tough time achieving academically, where there is a high level of violence, and where there have been shootings in the neighborhood.

A lot of the perpetrators of the violence are these children's parents. The reason I came to these schools is that these are people who do not seek services from the mental health system, because they do not trust the system. Many of the parents I work with have a history of involvement in the criminal justice system. They also have a history of unpleasant experiences with our system.

These six schools have a history of being constantly visited by Child Crisis and the police department. The challenge we took on was to figure out what we were overlooking. We asked ourselves, "What else can we do?"

I didn't walk onto the school campuses telling anyone what to do. I asked principals to just introduce me as a counselor and nice guy from the Department of Public Health, and please don't use the word "mental." Then I sat in the secretary's' office and watched the kids who were been sent there from the classrooms. Countless children were coming in for fighting, bizarre behavior, threatening behavior, and weapons.

I had to earn the principals' confidence. There was no trust at all in our system. They were feeling that DPH has failed to provide services to their schools, not realizing that from our side there are restrictions. I helped educate them about children's services. I helped the parents understand that they can ask for help, without anyone taking their child from them. I'm very careful not to promise people the world. I just promise that if you hang in there things will get better.

As time went on more and more people got to know me. I offered to come to their homes. The home visits are very important. At the end of April when I wrote the summary I've given you, I had done 50 home visits in the community.

Sometimes a family asks me to start coming with them to different functions. I attend church functions. Anything I'm asked to go to to provide support for families I go to.

I do individual counseling with the kids. We have nine open cases. These are very severe cases. One of the agencies I work very closely with is the San Francisco Police Department. On June 19th, I did a training for the Bayview Station and presented the techniques I use in working with the families.

These are high-risk home visits that I do. I notice activities. I knock on the door and get a gruff answer. Then that person with the gruff, grumbly voice says, "Oh, Keith is here," and invites me in.

I develop a plan to work with the child. I have group therapy. I have five groups on the campuses. In one group, six of the eight kids' fathers have been killed in gun violence. The other two had a close relative who was killed. All this was in the last year and a half.

I put the kids who fight into a group and they are now a team, so they don't have to fight anymore.

I was proud to be chosen by the staff, students, and parents to be the Graduation Speaker at Drew Elementary School.

In the time I've been at these schools, there have been zero hospitalizations, zero calls to police, and zero calls for mental health emergencies.

Ms. Ruffin: I just wanted to say that Keith has done an incredible job.

Family Mosaic Project
Dr. Frank: Thank you for inviting me here tonight. I'm the Clinical Director of FMP. The Executive Director position has been vacant since October. We anxiously await the filling of that position. We're waiting on budget news. The City is in the middle of negotiating the budget and the Governor is looking at cuts for children's services.

FMP is functioning with too low a level of staffing. A lot of people are waiting for our services. We'd appreciate any support from the Mental Health Board.

Most of the clients who come to Family Mosaic fall into the category of high users in the system, meaning they use in excess of $50,000 of services in a year. Our clients are disproportionately African American (52-64%). We have a two to one male to female ratio. The majority are teens and they live mainly in five neighborhoods in the southeast part of the city.

These clients utilize multiple systems, including, child welfare, out-of-home placements, inpatient services, and unfortunately sometimes they wind up in the juvenile probation system.

Oftentimes the families we work with have a history of child maltreatment, which requires intervention and out-of-home placement. It's often years before the problems are identified. Teachers complain about these kids, they get shifted from school to school, and they get labeled as problem kids.

There may be a family involved in treatment with the kids, but it may be that the family has split up. Some family members come and go which further traumatizes the kids. Because they are not identified and linked with services early on, they experience what I call failure of treatment, which has an impact on their self-esteem.

We're actually moving toward reaching children at a younger age. Younger children are much more amenable to services before the problems get embedded in their systems.

Most of the kids experience symptoms that are so serious they disrupt the child's ability to function in school or at home. One of the things we try to do in the first couple months after admission is a comprehensive assessment of the child and family.

Many of our kids experience disruptive behavior disorders. Many have attention deficit disorders and learning disabilities. We're seeing more and more kids with more serious psychiatric problems, including bi-polar and psychotic kids. We've seen kids as young as 11 or 12 with those diagnoses.

Mr. Nizzardini: With all the violence going on, how much post-traumatic stress do you see?

Dr. Frank: Almost all the kids we see have a concurrent diagnosis of Post Traumatic Stress Disorder. Then couple that with ADHD or a learning disability, and it's incredibly sad to see how these kids struggle and the families struggle.

What's different about Family Mosaic? We are strength-based and family-focused. Instead of starting by looking for what's wrong with the child and family, we look for the strengths they can build on. We come in and say we're not the expert, you are the expert on your child. We are coming in to help you.

We look at the big picture and bring in resources that will lessen the risk of out-of-home placement, and improve the quality of life of both the child and the family.

Typically many service providers work with the family. We come in and take the lead in coordinating all those providers,. We develop a plan of care and then provide services and support.

The outcome data we've collected show the lessening of symptoms and a reduction in residential treatment. The cost savings over time are into the millions. But what's most impressive is how significant a reduction there is in hospital days, and how the number of crimes drop.

We treat people with respect. We treat them as equal partners at the table.

Comprehensive Child Crisis Services
Ms. Downs: We're part of CMHS. We're staffed 24 hours/7 days a week with psychologist, social workers, and health workers. We see kids under the age of 18 for suicidal, homicidal, and out-of-control behavior. The bulk of referrals come from schools, residential treatment, the police department, and families.

We primarily see Medi-Cal clients, but we also serve privately insured kids.

Before we see the kids we try to get a consent form from the parents. Sometimes the referral source wants us to keep it a secret from the parent, but our job is to work with the parents.

We do a 5150 assessment. We determine if the child is safe. If not, we'll provide a 3-day involuntary stay in the hospital. But there is a shortage of hospital beds. So sometimes our staff have to stay with kids for 3 days straight. Sometimes we have to use hospitals as far away as Sacramento.

If child doesn't meet the criteria to go into the hospital, then we will work up a treatment plan with the family. We're open 24 hours a day, so parents can call us and we'll come back out to them and help.

We have a hands-off policy. We don't restrain kids. If there is a chance that a kid will need restraining, then we meet them at the hospital.

We also provide urgent care for children. We can provide counseling for individual children and families up to two months.

We do case management and will refer kids and families to FMP.

We just started a new program which works with the Foster Care Mental Health Program. Every week on Monday and Thursday, we set aside office hours with our psychiatrist and case worker for kids who need urgent care and have nowhere else to go.

Child Crisis works closely with the juvenile probation department. We work with kids to keep them from becoming repeat offenders.

We also work with Project Impact, which is a mobile support team of three who take referrals from the probation department and provide intensive wrap-around services to the children and the families.

Our staff speak Cantonese, Vietnamese, and Spanish.

Dr. Moses: Dr. Frank, I want to commend you for keeping FMP going since Dr. Zomalt left. I know it's hard to combine the clinical work with the administrative work. Are you still continuing the community advisory committee?

Dr. Frank: We continued it up to about two months ago. Then we expanded our family advisory team, and expanded our peer support program, which involves parents who have been in the system. Over time, the membership of the community advisory committee dwindled, so we put it on hold pending our family and youth information sharing day. We tried to recruit participation. Cynthia Billups is taking the lead on this and we're hoping it will start up in September again.

Dr. Moses: In light of the number of African American clients you have, what is the diversity of your staff?

Dr. Frank: We have a diverse staff which is reflective of the clients being served. We've had a lot of turnover the past year and have been unable to fill positions, but we pay a lot of attention to diversity of staff.

We have a satellite clinic at RAMS, which provides Asian-focused FMP services. We also have bi-lingual, bicultural Spanish-speaking, and Tagalog-speaking staff. We used to have a Cantonese speaking advocate, but she moved to another clinic in the system.

Dr. Moses: What plan do they have for filling the executive director job?

Ms. Ruffin: I know Sai-Ling, Director of the Children, Youth, and Family Section, has been working on getting the position free. Part of delay is that all of our vacant positions have been frozen for some time due to the budget crisis.

Dr. Frank: Dr. Zomalt had two roles. He was Executive Director of FMP and Associate Director for children's services. Sai-Ling has decided to split this position into two recognizing that FMP needs a full-time director.

Ms. Knight: What is the School District doing? I attended schools in San Francisco. I'm a native San Franciscan. At that time the schools had counselors and nurses. But now, I don't think there are many counselors and nurses. The Health Department is doing its part. What about the School District?

Dr. Frank: One of the things we do very actively is try to work with teachers and guidance counselors to help support the child. Often the kids who come to us are not in a setting that can meet their educational needs. One of the challenges for us is to convince the School District that you can't deal with academic needs without looking at the child's emotional needs.

The Family Involvement Team has been very helpful with this. They are a tremendous resource to us and to the families, but it's very difficult.

Ms. Shaffer: What I'm hearing is that it is very important to have someone who can manipulate and work with a very complicated special education system. When a child is diagnosed with a mental illness, that is an education issue. The School District is missing the boat on these children.

3.0 DIRECTORS REPORTS

3.1 Report from the Director of Community Mental Health Services

Ms. Ruffin reported as follows: Since we've been hearing about children's programs, I wanted to say that our Children, Youth, and Family Section is probably the most complete system of care in our department. They have a whole variety of levels of care, from prevention to acute services. They are always coordinating with other outside agencies, such as juvenile probation, foster care, child welfare, and the schools.

Ms Shaffer: In order to get into the system, you have to be Medi-Cal. Private sector families can't get in. When we look at the adult clients we have to ask, "Where were the services for them when they were younger?"

Ms. Ruffin: We have a single system of care. People can use our services regardless of their ability to pay. They can still call Child Crisis. Some services would be cost-linked. But they do not have to be Medi-Cal. We have a single standard of care for Medi-Cal and non-Medi-Cal people.

The Director's written report was distributed:

Budget Update. GOOD NEWS! The Board of Supervisors has added back the $500,000 in cuts to CMHS that were distributed among the fee for service hospitals, IMDs, and the Private Provider Network. A 1% COLA for non-profit contractors has also been approved. There is a small chance that if the negotiations with the unions on retirement payback are successful the COLA may increase to 3%.

Children System of Care Parent Youth Conference. The first ever, Children System of Care Parent Youth Conference was held on May 18, 2002. It was a very successful event which attracted attendance from parents, grandparents, community providers and youth and department representatives (DCYF, SFUSD, Juvenile Probation, and Department of Human services). Information provided included the rights and responsibilities of parents and youth in the mental health system, child welfare system, and juvenile justice system. Youth from the Youth Advisory Board also shared their experience through poetry that they composed. The event was also enhanced by entertainment by youth performance and door prizes.

The Children's System of Care funds continue to be at risk in the state budget. San Francisco has approximately $1 Million in such Children's SOC finds.

Suicide Prevention Workgroup. The Child, Youth and Family System of Care convened a Suicide Prevention Workgroup at the request of the Board of the Supervisors. In response to the recent tragedy of a completed suicide by a promising high school student in our local high school, the committee is charged with reviewing the various factors leading to suicide in young people as well as reviewing the existing protocol for suicide intervention and suicide prevention among city departments, and public and private agencies. In addition, the committee will be making recommendations to the board on ways to address current gaps in services. The completed report is attached.

Monique Zmuda. Monique Zmuda, the CFO for the Department of Public Health is leaving to become the Deputy Controller for the City. Gregg Sass, the CFO for the Community Health Network, will be the new CFO for DPH.

Legislative Analyst. The CMHS legislative analyst is Nick Hancock. Nick assumed this responsibility from Louise Rogers following her departure for San Mateo County a few months ago.

There is a state law that requires that hospitals meet very stringent seismic laws in the coming years. At the next Health Commission meeting there will be a report on the recommendations of a consultant on whether San Francisco General Hospital should be rebuilt where it is now or rebuilt in partnership with UCSF at Mission Bay.

If the hospital were to be rebuilt at UCSF at Mission Bay, one proposal is to leave the inpatient psychiatry units back at the old campus on Potrero. There are some issues and concerns you would want to keep your eye on. What would be the impact if the medical services were not right there on site for the psychiatric inpatients? There could be a benefit if the Department of Psychiatry were turned into a center for excellence in psychiatry.

I wanted to also say how much I have enjoyed working with you, and how sorry I am to leave you. I'm so proud of you. I think you do a terrific job and don't let anybody tell you differently.

Dr. Moses: I'm so happy to hear we're going to have the money back. I want to say thank you to Aaron Peskin, and everyone else who made this possible.

Ms. Ruffin: We didn't just get $500,000 reinstated. We started out with a proposed loss of $12 million.

Mr. Douglas: Is anybody doing anything about the possibility of getting some money for the 24-hour drop-in center?

Ms. Ruffin: It isn't in the budget for next year at this point. I finally had the chance to read your Annual Report and I appreciate that you identify the drop-in center as one of two priorities along with Mobile Crisis. The planning is done, we've got a good project together, but the budget wouldn't allow it. But don't give up.

Mr. Douglas: Is it possible to combine those two ideas and put Mobile Crisis and the 24-hour drop-in center together? Ms. Ruffin: The problem is that we don't have funds for 24/7 for either one. We could look at whether it make sense to co-locate those programs if the money were there.

3.2 Report from the Executive Director of the Mental Health Board

Ms. Brooke: I just want to commend the Board members for your testimony at hearings and for sending letters, as well as for your the work on the Annual Report. I think it really made a difference.

4.0 MENTAL HEALTH BOARD COMMITTEES

4.1 Report of the Chair of the Board and Executive Committee.

Mr. Stinson: I wanted to discuss two things:

First, we were talking at the meeting of the Executive Committee about how we have a lot of newer members on the Board. I remember when I was first on the Board, I was so overwhelmed by all the terminology and all the information. I want you to know if you are feeling that way, you're not the first person. I want to assure you that the knowledge comes and with each Board meeting you'll learn more and more. Please feel free to ask questions anytime you don't understand something.

Also please feel free to call Helynna or Rich at any time. They are incredibly busy, but you are their top priority. They want to help you, and help you get up to speed, and empower you to do the things you want to do on the Board.

Toye made a suggestion that we put into place a mentorship program. This would be for all the people who have been on the Board for less than six months. A veteran Board member would give you a call and ask how you're doing.

Ms. Buckins: I think it should go a little further than that. I'm new to the Board. I went to the Reception for the Board of Supervisors. I felt a little intimidated. I don't understand San Francisco politics. I don't have a college degree. I'm a mother of four, so how will I find the time to network? It would be kind of nice for older Board members to ask us to come with them when they're networking.

Mr. Stinson: I think that's something we can absolutely arrange. We'll work with you to find something that works for you.

Ms. Walker: Robyn, I saw you at the Reception and you were a smoothie. I had no idea you were not feeling comfortable. Ms. Buckins: It's called the gift of gab.

Ms. Ruffin: My staff are available to provide orientations to the mental health system in a group or even one on one.

Mr. Stinson: The second issue I wanted to talk about is our MHB committee structure. Among the commitments we ask of our members is to attend the monthly meetings of one of our committees. During the last few months, we've had two committees focused on the budget. The Executive Committee decided to move beyond these temporary committees to more permanent committees.

There are two committees we are recommending. Each will have a chair and co-chair. The chair will be responsible for setting the agenda and managing the meeting. The co-chair will be active in both of those duties and will be able to step in if the chair was not able to assume that role.

The first committee will be Program and Services, with a primary mandate around program reviews. They will organize those reviews and manage Board members' training. They will take an active role in looking at local and state legislation. They'll be looking at the recovery model. They'll be looking at the coordination between CMHS and the police department. They'll also be dealing with some children's issues.

The second committee will be the Public Education Committee. The committee has been called the Media Strategies Committee, and the idea was to focus on media and doing effective outreach and advocacy. This committee was particularly successful over the past few months and we want to make it an explicit part of what we do. They'll also be dealing with some children's issues.

At this point, what I want to do is open up a discussion of whether these committees make sense. These are not set in stone, but by the same token we do need to get going.

Dr. Del Zotto: In terms of media and outreach, the emphasis is media and beyond. Sometimes there are problems with disseminating information within communities and in the mental health system. We need to look, too, at community systems of information dissemination.

Mr. Martin: One thing that's starting to become an issue is knowing things in a timely manner. I'm wondering if part of the role of media and outreach could be communications within the Board. I'm wondering if we can explore ways we can get things out in a more timely manner, maybe a Mental Health Board list serve.

Mr. Stinson: I would suggest that this committee would take as a mandate how can we leverage Rich and Helynna and their resources to solving the issue. If you have additional comments on the committee structure, please call me, Helynna, or Rich. The goal to make decisions by the end of week.

Since we are so short on time, I propose that we table until our next meeting the resolution titled "In Support of Supervisor Maxwell's Initiative to Streamline the City's Contracting Process."

5.0 PUBLIC COMMENT

Mr. Wise: In the last two and a half months, two close friends, both clients of CMHS went to Laguna Honda, one for an amputation and one for stroke. I saw on the news that there was a rally at City Hall for some of the health care workers and laundry workers who were budgeted out. But I can tell you there are a lot of mental health consumers at Laguna Honda. I hope we can support the union to try to keep those people working. I wanted to bring the issue to the attention of the Board. Laguna Honda really is a godsend.

Mr. Kalman: Basically I listened to one of Newsom's presentations on care not cash. I think it is a big help to people with mental health issues, because he says there will be guaranteed services. Is anyone from DPH analyzing those services?

There being no further business, the meeting was adjourned at 8:37 p.m.

SAN FRANCISCO MENTAL HEALTH BOARD

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THE REGULARLY SCHEDULED MEETING OF THE MENTAL HEALTH BOARD

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WEDNESDAY, AUGUST 14, 2002
IS CANCELLED

YOU ARE INVITED TO ATTEND

THE PROGRAM AND SERVICES COMMITTEE

THURSDAY, AUGUST 15, 2002

6:30 - 8:30 PM

1380 HOWARD ST, ROOM 537

Members of the public, consumers, family members, mental health professionals, and CMHS program providers are encouraged to attend. The committee will hold a hearing on the Mental Health Board's Program Review format.

For the past ten years, the Mental Health Board has reviewed ten to twenty programs annually that are contracted by CMHS to provide services. Board members have interviewed staff and clients and contributed a portion of the score that programs receive from CMHS.

The Board would like to develop its own Program Review format, and submit comprehensive reports to the Director of Community Mental Health Services for each program reviewed. The reviews would be done between September and February so that the department would have the information prior to approvals of new contracts.

Input from the public, and from providers about this review process would be greatly appreciated. We welcome your ideas about how we could do the most effective reviews of programs.

SAN FRANCISCO MENTAL HEALTH BOARD

SEAL OF THE CITY AND COUNTY OF SAN FRANCISCO

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NOTICE OF MEETING..

PROGRAM & SERVICES COMMITTEE

Thursday, August 15, 2002
1380 Howard Street, Room 537
6:30 p.m.

AGENDA

1. WELCOME AND INTRODUCTIONS

Carol Knight is chair of the committee and Idell Wilson is co-chair. The chair will introduce the committee and then members of the public will introduce themselves.

2. PRESENTATION ABOUT THE MENTAL HEALTH BOARD ROLE IN PROGRAM REVIEWS

Staff will provide an overview of the role that the Mental Health Board has played in program reviews for Community Mental Health Services for the past decade, and give a description of the new proposal.

Following a discussion by board members, members of the public, consumers, family members, mental health professionals, and CMHS program providers are encouraged to give input.

3. ADJOURNMENT

This agenda and all attachments can be viewed at: www.ci.sf.ca.us/mental_health. Attachments are also available at the Mental Health Board Office, 1380 Howard Street, Suite 510, telephone 255-3474.

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MEETING OF THE MENTAL HEALTH BOARD

Wednesday, September 11, 2002
1380 Howard, Room 537
6:30 p.m.

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AGENDA

Public comments will be taken for each agenda item.

09-09-02A10:35 RCVD

1.0 CALL TO ORDER AND CONSENT CALENDAR (5 min)

For discussion and proposed action

1.1 Call to Order and Announcements from the Chair

1.2 Consent Calendar (Attachment A)

1.2.a PROPOSED ACTION: Be it resolved that the minutes of the Mental Health Board meeting of July 10, 2002, be approved as submitted.

1.2.b PROPOSED ACTION: Be it resolved that the Mental Health Board grants leaves of absence for the meeting of September 11, 2002, to the following members:
Carol Knight

2.0 SEPTEMBER 11, 2001

Moment of Silence

3.0 PRESENTATION: San Francisco Emergency Response Plan and Post Traumatic Stress Disorder (55 min.)

For discussion

Ann Stangby, RN, CEM, Emergency Response Planner, Department of Public Health
Dr. Paul Koller, Senior Psychologist, San Francisco Veteran's Administration Medical Center, Post Traumatic Stress Disorder Treatment Team, and Assistant Clinical Professor, UCSF Medical School, Department of Psychiatry.

4.0 DIRECTORS REPORTS (30 min)

For discussion

4.1 Report from the Director of Community Mental Health Services
A report on the activities and operations of Community Mental Health Services, including budget, planning, policy, and programs and services.

4.2 Report from the Executive Director of the Mental Health Board

A report including updates and announcements regarding the activities and operations of the Board.

5.0 MENTAL HEALTH BOARD COMMITTEES (20 min)

For discussion and proposed action

5.1 Report of the Chair of the Board and Executive Committee

The chair will report discussions and actions of Executive Committee.

5.1 a PROPOSED ACTION: Be it resolved that the Mental Health Board commends Supervisor Sophie Maxwell for her role in creating a task force to review the City's contracting procedures. (Attachment B)

5.1 b PROPOSED ACTION: Be it resolved that the Mental Health Board notified the Director of Community Mental Health Services that we have reviewed their contract with the State Department of Mental Health. (Attachment C)

5.1.c PROPOSED ACTION: Be it resolved that the Mental Health Board send a letter to Robert Cabaj, M.D, Director, Community Mental Health Services and Community Behavioral Health Services, stating that the Board has reviewed the federal SAMHSA (Substance Abuse and Mental Health Services Administration) renewal application for fiscal year 2002/03 funds and that the Board gives its full approval and support to this grant. (Attachment D)

5.2 Report from Program and Services Committee

5.2 a PROPOSED ACTION: Be it resolved that the Mental Health Board review 10 - 20 Community Mental Health Service programs annually, from September through February, independently and separately from the Quality Management Department program reviews.

6.0 PUBLIC COMMENT (10 minutes)

This is an opportunity for members of the public to address the Mental Health Board on items of interest to the public that are within the subject matter jurisdiction of the Mental Health Board. Additionally, public comments will be taken for each agenda item.

This agenda and all attachments can be viewed at: www.sfgov.org/mental_health. Agendas and attachments are also available at the Mental Health Board Office, 1380 Howard Street, Suite 510, telephone 255-3474.

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MENTAL HEALTH BOARD
ATTACHMENT A
September 11, 2002

CONSENT CALENDAR

All items on the Consent Calendar are handled through a single vote. There will be no discussion unless a member requests it, in which case the item will be removed from Consent Calendar and discussed. Additional names may be added to the leave of absence resolution during the meeting.

1.2.a **PROPOSED RESOLUTION: Be it resolved that the minutes of the Mental Health Board meeting of July 10, 2002, be approved as submitted.**

1.2.b **PROPOSED RESOLUTION: Be it resolved that the Mental Health Board grants leaves of absence for the meeting of September 11, 2002, to the following members: Carol Knight.**

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MENTAL HEALTH BOARD
ATTACHMENT B
September 11, 2002

PROPOSED RESOLUTION (MHB-2002-xx) IN SUPPORT OF SUPERVISOR SOPHIE MAXWELL'S INITIATIVE TO STREAMLINE THE CITY'S CONTRACTING PROCESS

WHEREAS, many nonprofit agencies which provide services to the City and County of San Francisco have contracts with a number of different City departments at the same time, and

WHEREAS, these City departments require the same nonprofit agencies to provide the same information in very different formats, and

WHEREAS, this variety of formats does not add any specific value to the contracting process for the City, and

WHEREAS, the nonprofit agencies have to spend a significant amount of administrative time to comply with the differing formats, and

WHEREAS, the nonprofit agencies need to be spending their resources as much as possible on services rather than duplicative administrative work, and

WHEREAS, the San Francisco Human Services Network has asked for a standardization of the format for core information, and

WHEREAS, Supervisor Sophie Maxwell is working closely with the San Francisco Human Services Network to create effective strategies and solutions; now, therefore

BE IT RESOLVED, that the Mental Health Board expresses its gratitude to Supervisor Maxwell for her leadership in creating the City Contracting Task Force, for her commitment to maximizing resources spent on direct services while reducing duplicative administrative work, for boosting the morale of the nonprofit agencies which provide services to the City, and for her abiding concern for the people of San Francisco who are in need.

Resolution establishing a City Contracting Task Force to review and make recommendation to the Board on possible legislative and budgetary actions relating to the City's policies and practices regarding contracting vital human health, safety, and affordable housing services with non-profit organizations.

WHEREAS, Non-profit, community-based organizations play a key role in the delivery of critically needed health and human service to those in need in San Francisco; and

WHEREAS, Non-profit organizations form the foundation for the broad and complex safety net supporting San Francisco's diverse populations; and,

WHEREAS, The City has developed a complex set of contractual relationships with these non-profits to deliver essential social, affordable housing, and health services to needy San Franciscans; and,

WHEREAS, The Civil Grand Jury has found that the City's current system of management is too decentralized and places administrative burdens on non-profit organizations; and,

WHEREAS, The Civil Grand Jury has found that procedures vary widely from each department, that organizations may have contracts with several departments and that information regarding organizations and contracts is not effectively shared between departments; and,

WHEREAS, Failure to address this growing burden for the non-profit community can and will ultimately create a crisis at the core of this city's safety net, wasting scarce resources directed at the San Franciscoís most vulnerable population; now, therefore, be it

RESOLVED, That the Board of Supervisors ("Board") hereby establishes a City Non-Profit Contracting Task Force ("Task Force") to review and make recommendations Report to the Board. The full Board shall consider Task Force recommendations including but not limited to new ordinances, administrative procedures, and suggested departmental regulations addressing the coordination of policies and practices across and within City departments regarding:

1) Contract certification; and
2) Contract management and performance evaluation; and
3) Contract payment and revenue management, and
4) Any other matters relating to City contracting with non-profit health and human services providers referred to it by the Board, and be it

FURTHER RESOLVED, That the Task Force shall consist of fourteen members, seven of whom are appointed by and serving at the pleasure of the Board and six of whom are heads of City departments appointed by the Mayor; and, be it

FURTHER RESOLVED, That seven of the members shall be employees of the City and shall represent key City departments responsible for the majority of City contracts:

1) The City Controller;

2) The Director of the Department of Public Health, or a designee;
3) The Director of the Department of Human Services, or a designee;
4) The Director of the Department of Aging and Adult Services, or a designee;
5) The Director of the Mayor's Office of Community Development, or a designee;
6) The Director of the Department of Child, Youth and Families, or a designee;
7) The Director of the Office of Contract Administration; and, be it

FURTHER RESOLVED, That the seven remaining members of the Task Force shall be representatives of non-profit health, affordable housing development, and human service organizations; and, be it

FURTHER RESOLVED, That these seven members shall to the extent possible represent agencies with:

1) Contracts from multiple City departments; or
2) Multiple contracts with a single City department; or
3) Varying agency budget sizes; and, be it

FURTHER RESOLVED, That the Task Force shall convene within 45 days of the effective date of the ordinance and shall expire one year later, unless its powers are renewed by the Board; and, be it

FURTHER RESOLVED, That the Task Force will produce a report with its conclusions and recommendations to the Board within six months and that the report and recommendations be the subject of a public hearing before a Committee of the Board and that Committee shall consider and refer to the full Board its recommendations for actions including but not limited to new ordinances, administrative procedures and suggested departmental regulations; and, be it

FURTHER RESOLVED, That the City Attorney's Office shall provide legal assistance to the Taskforce; and, be it

FURTHER RESOLVED, That the Office of Administrative Services shall provide administrative support for the Task Force; and, be it

FURTHER RESOLVED, That subject to federal and state law, the Task Force shall have full and complete access to any and all documents related to the management of City contracts with non-profit health and human service providers; and, be it

FURTHER RESOLVED, That all City departments, boards, commissions and employees shall cooperate fully with the Task Force; and, be it

FURTHER RESOLVED, That all City departments, boards, commissions and employees shall provide honest and forthright information to the Task Force to assist the Task Force in its conclusions and recommendations.

SAN FRANCISCO MENTAL HEALTH BOARD

1380 Howard Street, Suite 510
San Francisco, CA 94103
(415) 255-3474 fax: 255-3760
mhb@igc.org
www.sfgov.org/mental_health

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MENTAL HEALTH BOARD
ATTACHMENT C
September 11, 2002

REVIEW OF THE STATE CONTRACT

Enclosed is a copy of the contract the Department of Public Health signs with the State Department of Mental Health in order to receive San Francisco's portion of state funding for community mental Health Services.

The first page of the contract, stating the dollar amount, is the only page that varies from county to county. The rest of the contract is the standard language for all counties.

PROPOSED RESOLUTION

Be it resolved that the Mental Health Board send a letter to Robert Cabaj, M.D., Director, Community Mental Health Services and Community Behavioral Health Services, stating that the Board has reviewed Contract 02-72041, which is the contract the San Francisco Department of Public Health has with the State Department of Mental Health for a total of $3,844,098 in funding for community mental health services.

July 1

Jo R
San
13
Sa

Mental Health

1600 9th Street, Sacramento, CA 95814
(916) 654-3589

July 17, 2002

Jo Ruffin, Director
San Francisco County Mental Health
1380 Howard Street, 5th Floor
San Francisco, CA 94103

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PUBLIC LIBRARY

RE: Contract No: 02-72041 Amendment No: 0

Dear Contractor:

The enclosed agreement has been approved by the State and should be retained for your records.

For program matters and for submission of invoices, please contact:

DMH
Systems Implementation and Support
1600 9th Street
Sacramento, CA 95814

Telephone: (916) 654-2528

Sincerely,

Marisol Parisi

Marisol Parisi
Administrative Services

Enclosures

cc: Lana Teves
Systems Implementation and Support

of California
ANDARD AGREEMENT
213 (NEW 02/98)

CONTRACTOR COPY

Agreement Number	Amendment Nbr.
02-72041-000	

This Agreement is entered into between the State Agency and the Contractor name below:

State Agency's Name:

Department of Mental Health

Contractor's Name:

San Francisco County Mental Health

The Term of this Agreement is: **July 01, 2002 Through June 30, 2002**

The maximum amount of this agreement is: **$3,844,098.00**
Three Million Eight Hundred Forty-Four Thousand Ninety-Eight Dollars and No Cents.

The parties agree to comply with the terms and conditions of the following exhibits which are by this reference made a part of the Agreement:

Exhibit A - Scope of Work	Page(s)	21	
Exhibit B - Budget Detail and Payment Provision	Page(s)	4	
* Exhibit C - General Terms and Conditions	Form:	GTC 201	Dated 02/20/2001
Exhibit D - Special Terms and Conditions	Page(s)	4	
Exhibit E - Additional Provision	Page(s)	8	

*View at: www.dgs.ca.gov/contracts

IN WITNESS WHEREOF, this Agreement has been executed by the parties hereto.

CONTRACTOR

CONTRACTOR'S NAME *(If other than an individual, state whether a corporation, partnership, etc.)*
San Francisco County Mental Health

BY *(Authorized Signature)*

DATE SIGNED

PRINTED NAME AND TITLE OF PERSON SIGNING
MITCHELL KATZ, MD - DIRECTOR OF HEALTH

ADDRESS
1380 Howard Street, 5th Floor
San Francisco, CA 94103

STATE OF CALIFORNIA

AGENCY NAME
Department of Mental Health

BY *Authorized Signature*
William A. Arnett Jr

DATE SIGNED
6/24/02

PRINTED NAME AND TITLE OF PERSON SIGNING
Linda A. Powell, Deputy Director
Administrative Services

ADDRESS
1600 9th Street
Sacramento, CA 95814

California
Department of General Services
Use Only

FULLY EXECUTED

San Francisco County Mental Health
Contract Number: 02-72041-000
Exhibit A
Page 1 of 1

EXHIBIT A
SCOPE OF WORK
JULY 1, 2002 – JUNE 30, 2003

1. The Contractor agrees to provide to the Department of Mental Health the services described herein: Provide specialty mental health services to Medi-Cal beneficiaries of San Francisco County within the scope of services defined in this contract.

2. The services shall be performed at appropriate sites as described in this contract.

3. The services shall be provided at the times required by this contract.

4. The project representatives during the term of this agreement will be:

Department of Mental Health Ruth Walz (707) 252-3168 Fax: (707) 2421	San Francisco County Mental Health Jo Ruffin, Director (415) 255-3401

Direct all inquiries to:

Department of Mental Health Technical Assistance and Training 1600 9th Street, Room 100 Sacramento, CA 95814	San Francisco County Mental Health Jo Ruffin, Director 1380 Howard Street, 5th Floor San Francisco, CA 94103

Either party may make changes to the information above by giving written notice to the other party. Said changes shall not require an amendment to this contract.

5. See Exhibit A, Attachment 1, which is made part of this contract, for a detailed description of the work to be performed.

SERVICE DELIVERY. ADMINISTRATIVE AND OPERATIONAL REQUIREMENTS

A. Provision of Services

The Contractor shall provide, or arrange and pay for, covered services to beneficiaries, as defined for the purposes of this contract, of San Francisco County.

In determining whether a service is covered under this contract based on the diagnosis of the beneficiary, the Contractor may not exclude a beneficiary solely on the grounds that the provider making the diagnosis has used the International Classification of Diseases (ICD) diagnosis system rather than the system contained in the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association. For services provided pursuant to Section C, the Contractor will consider the following ICD-9 diagnoses codes as included. For any other service, the Contractor may consider these codes as included or may require the provider to use DSM IV.

Table 1 - Included ICD-9 Diagnoses - All Places of Services Except Hospital Inpatient

295.00 – 298.9	302.8 - 302.9	311 - 313.82
299.1 – 300.89	307.1	313.89 – 314.9
301.0 – 301.6	307.3	332.1 – 333.99 *
301.8 – 301.9	307.5 - 307.89	787.6
302.1 – 302.6	308.0 - 309.9	

*Note: Treatment of diagnoses 332.1 - 333.99, Medication Induced Movement Disorders, is a covered service only when the Medication Induced Movement Disorder is related to one or more included diagnoses.

Table 2 - Included ICD-9 Diagnoses - Hospital Inpatient Place of Service

290.12 – 290.21	299.10 - 300.15	308.0 – 309.9
290.42 – 290.43	300.2 - 300.89	311 – 312.23
291.3	301.0 - 301.5	312.33 - 312.35
291.5 - 291.89	301.59 - 301.9	312.4 – 313.23
292.1 - 292.12	307.1	313.8 – 313.82
292.84 – 292.89	307.20 - 307.3	313.89 - 314.9
295.00 – 299.00	307.5 - 307.89	787.6

B. Availability and Accessibility of Service

The Contractor shall ensure the availability and accessibility of adequate numbers of institutional facilities, service locations, service sites, and professional, allied and supportive personnel to provide medically necessary services, and ensure the authorization of services for urgent conditions on a one-hour basis.

C. Emergency Psychiatric Condition Reimbursement

The Contractor shall pay for services for emergency psychiatric conditions received by a beneficiary from providers, whether or not the provider has a subcontract with the Contractor. Such services will not be subject to prior authorization by the Contractor.

D. Organizational and Administrative Capability

The Contractor shall have the organizational and administrative capabilities to carry out its duties and responsibilities under the contract. This will include as a minimum the following:

1. Designated persons, qualified by training or experience, to be responsible for the provision of covered services, authorization responsibilities and quality management duties.
2. Beneficiary problem resolution processes.
3. Provider problem resolution and appeal processes.
4. Data reporting capabilities sufficient to provide necessary and timely reports to the Department.
5. Financial records and books of account maintained, using a generally accepted method of accounting, which fully disclose the disposition of all Medi-Cal program funds received.

E. Quality Management

The Contractor shall implement a Quality Management Program in accordance with Title 9, CCR, Section 1810.440 and Appendix A (consisting of three pages) and Appendix B (consisting of two pages), which are incorporated herein by reference, for evaluating the appropriateness and quality of the covered services provided to beneficiaries. References to the mental health plan (MHP) in Appendices A and B are references to the Contractor. Provide the Department with reports generated through the Quality Management Program on request.

The Contractor shall ensure that all covered services delivered by organizational providers are provided under the direction of a physician; a licensed/waivered psychologist; a licensed/registered/waivered social worker; a licensed/registered/waivered marriage, family and child counselor; or a registered nurse.

The Contractor shall include a study of Latino access in the annual Quality Improvement Workplan required by Appendix A, Section B that is effective on or after July 1, 2002. The required study may examine initial or secondary access issues. Initial access studies may include, but are not limited to studies of: outreach efforts to increase access, stigma, and healthcare/mental health partnerships related to access. Secondary access studies may include, but are not limited to studies of retention, the effect of extended hours, or barriers for Latinos with limited english proficiency. The required study shall, at the Contractor's election, meet the Contractor's obligation to conduct any single item required by Appendix A, Section B, Items 1, 2, 3, or 5. The required study may also meet the Contractor's obligation to conduct one of the clinical studies required by Appendix A, Section B, Item 4, if the Contractor will be studying a clinical issue related to access. The Contractor may chose to develop an access study that includes Latino and other underserved populations, rather than a study that focuses exclusively on Latino populations. The Contractor shall provide the Department with information on the design, progress and outcome of the study upon request.

F. Beneficiary Records

The Contractor shall maintain at a site designated by the Contractor for each beneficiary who has received services a legible record kept in detail consistent with Appendix C (consisting of three pages), which is incorporated herein by reference, and good professional practice which permits effective quality management processes and external operational audit processes, and which facilitates an adequate system for follow-up treatment. References to the client in Appendix C are references to beneficiaries who have received services through the Contractor. If a beneficiary receives only psychiatric inpatient hospital services, the Contractor need not maintain a record for the beneficiary in addition to the record maintained by the facility, provided the Contractor and appropriate oversight entities have access to the facility's record as provided in Exhibit E, Section 6, Item D.g.

G. Review Assistance

The Contractor shall provide any necessary assistance to the Department in its conduct of facility inspections and operational reviews of the quality of care being provided to beneficiaries, including providing the Department with any requested documentation or reports in advance of a scheduled on site review. Contractor will correct deficiencies as identified by such inspections and reviews according to the time frames delineated in the resulting reports.

H. Implementation Plan

The Contractor shall comply with the provisions of the Contractor's Implementation Plan for Consolidation of Medi-Cal Specialty Mental Health Services pursuant Title 9, CCR, Section 1810.310 as approved by the Department, including the administration of beneficiary problem resolution processes as required by Title 9, CCR, Section 1850.205. The Contractor shall obtain written approval from the Department prior to making any changes to the Implementation Plan as approved by the Department. Contractor may implement the changes after 30 calendar days if no notice is received from the Department, as provided in Title 9, CCR, Section 1810.310.

I. Memorandum of Understanding with Medi-Cal Managed Care Plans.

The Contractor shall enter into a Memorandum of Understanding (MOU) with any Medi-Cal managed care plan serving the Contractor's beneficiaries in accordance with Title 9, CCR, Section 1810.370. The Contractor shall notify the Department in writing if the Contractor is unable to enter into an MOU or if an MOU is terminated, providing a description of the Contractor's good faith efforts to enter into or maintain the MOU.

J. Cultural Competence Plan

The Contractor shall comply with the provisions of the Contractor's Cultural Competence Plan submitted in accordance with Title 9, CCR, Section 1810.410, and approved by the Department. The Contractor shall comply with any changes to Cultural Competence Plan requirements and standards for cultural and linguistic competence established by the Department to be effective during the term of the contract. The Contractor shall provide an update on the Cultural Competence Plan as required by Title 9, CCR, Section 1810.410(c) in a format to be determined by the Department.

K. Certification of Organizational Providers

The Contractor shall certify the organizational providers that subcontract with the Contractor to provide covered services in accordance with Title 9, CCR, Section 1810.435 and the requirements specified in Appendix D (consisting of two pages), which is herein incorporated by reference, prior to the date on which the provider begins to deliver services under the contract, and once every two years after that date, except as provided in this section and in Appendix D.. The on site review required by Title 9, CCR, Section 1810.435(d) as a part of the certification process, will be made of any site owned, leased, or operated by the provider and used to deliver covered services to beneficiaries, except that on-site review is not required for public school or satellite sites.

If the Department has performed a similar certification of the provider for participation in the Short-Doyle/Medi-Cal program, certification by the Contractor is not required prior to delivery of services under this contract and the next certification will be due within two years of the date of the last certification by the Department, except as provided in Appendix D.

The Contractor may allow an organizational provider to begin delivering covered services to beneficiaries at a site subject to on site review prior to the date of the on site review, provided the site is operational and has any required fire clearances. The earliest date the provider may begin delivering covered services at a site subject to on site review is the latest of the date the provider requested certification in accordance with the Contractor's certification procedures, the date the site was operational or the date a required fire clearance was obtained. The Contractor shall complete any required on-site review of a provider's sites within six months of the date the provider begins delivering covered services to beneficiaries at the site.

The Contractor may allow an organizational provider to continue delivering covered services to beneficiaries at a site subject to on site review as part of the biennial recertification process prior to the date of the on site review, provided the site is operational and has any required fire clearances. The Contractor shall complete any required on-site review of a provider's sites within six months of the date the biennial recertification of the provider is due.

Nothing in this section precludes the Department from establishing procedures for issuance of separate provider identification numbers for each of the sites operated by an organizational provider to facilitate the claiming of federal financial participation by the Contractor and the Department's tracking of that information.

L. Recovery from Other Sources or Providers

The Contractor shall recover the value of covered services rendered to beneficiaries whenever the beneficiaries are covered for the same services, either fully or partially, under any other state or federal medical care program or under other contractual or legal entitlement including, but not limited to, a private group or indemnification program, but excluding instances of the tort liability of a third party or casualty liability insurance. The moneys recovered are retained by the Contractor; however, contractor claims for federal financial participation for services provided to beneficiaries under this contract will be reduced by the amount recovered. Nothing in this section supersedes the Contractor's obligation to follow federal requirements for claiming federal financial participation for services provided to beneficiaries with other coverage under this contract as described in DMH Letter No. 95-01, dated January 31, 1995, or subsequent DMH Letters on this subject.

M. Third-Party Tort and Casualty Liability Insurance

The Contractor shall make no claim for recovery of the value of covered services rendered to a beneficiary when such recovery would result from an action involving the tort liability of a third party or casualty liability insurance including workers' compensation awards and uninsured motorists coverage. The Contractor will identify and notify the State Department of Health Services of cases in which an action by the beneficiary involving the tort or casualty liability of a third party could result in recovery by the recipient of funds to which the State Department of Health Services has lien rights. Such cases will be referred to the State Department of Health Services within 10 days of discovery. To assist the State Department of Health Services in exercising its responsibility for such recoveries, the Contractor will meet the following requirements:

1. If the State Department Health Services requests payment information and/or copies of paid invoices/claims for covered services to a beneficiary, the Contractor will deliver the requested information within 30 days of the request. The value of the covered services will be calculated as the usual, customary and reasonable charge made to the general public for similar services or the amount paid to subcontracted providers or out of plan providers for similar services.

2. Information to be delivered will contain the following data items:

    a. Beneficiary name.

    b. Full 14 digit Medi-Cal number.

    c. Social Security Number.

    d. Date of birth.

    e. Contractor name.

    f. Provider name (if different from the Contractor)

    g. Dates of service.

    h. Diagnosis code and/or description of illness.

    I. Procedure code and/or description of services rendered.

    j. Amount billed by a subcontractor or out of plan provider to the Contractor (if applicable).

    k. Amount paid by other health insurance to the Contractor or subcontractor.

    l. Amount and date paid by the Contractor to subcontractor or out of plan provider (if applicable).

    m. Date of denial and reasons (if applicable).

3. The Contractor will identify to the State Department of Health Services the name, address and telephone number of the person responsible for receiving and complying with requests for mandatory and/or optional at-risk service information.

4. If the Contractor receives any requests by subpoena from attorneys, insurers or beneficiaries for copies of bills, the Contractor will provide the State

Department of Health Services with a copy of any document released as a result of such request, and will provide the name and address and telephone number of the requesting party.

5. Information reported to the State Department of Health Services pursuant to this Section will be sent to: State Department of Health Services, Third Party Liability Branch, 591 North 7th Street, Sacramento, California 95814

N. Financial Resources

1. The Contractor shall maintain adequate financial resources to carry out its obligation under this contract.

2. The Contractor shall have sufficient funds on deposit with the Department in accordance with Section 5778(l), W&I Code as the matching funds necessary for federal financial participation to ensure timely payment of claims for inpatient services and associated administrative days if applicable.

O. Financial Report

The Contractor shall report the unexpended funds allocated pursuant to Exhibit B to the Department, using methods and procedures established by the Department, if payments under this contract exceed the cost of covered services, utilization review and administration. The Contractor will not be required to return any excess to the Department.

P. Books and Records

The Contractor shall maintain such books and records necessary to disclose how the Contractor discharged its obligations under this contract. These books and records will disclose the quantity of covered services provided under this contract, the quality of those services, the manner and amount of payment made for those services, the beneficiaries eligible to receive covered services, the manner in which the Contractor administered its daily business, and the cost thereof.

Such books and records will include, but are not limited to, all physical records originated or prepared pursuant to the performance under this contract including working papers; reports submitted to the Department; financial records; all medical and treatment records, medical charts and prescription files; and other documentation pertaining to services rendered to beneficiaries. These books and records will be maintained for a minimum of five years from the termination date of this contract, or, in the event the Contractor has been duly notified that the Department, HHS, or the Comptroller General of the United States, or their duly authorized representatives, have commenced an audit or investigation of the contract, until such time as the matter under audit or investigation has been resolved, whichever is later.

The Contractor agrees to place in each of its subcontracts, which are in excess of $10,000 and utilize State funds, a provision that: "The contracting parties shall be subject to the examination and audit of the Auditor General for a period of three years after final payment under contract (Government Code, Section 8546.7)." The Contractor will also be subject to the examination and audit of the State Auditor General for a period of three years after final payment under contract (Government Code, Section 8546.7).

Q. Transfer of Care

Prior to the termination or expiration of this contract and upon request by the Department, the Contractor will assist the State in the orderly transfer of beneficiaries' mental health care. In doing this, the Contractor will make available to the Department copies of medical records, patient files, and any other pertinent information, including information maintained by any subcontractor, necessary for efficient case management of beneficiaries, as determined by the Department. Costs of reproduction will be borne by the Department. In no circumstances will a beneficiary be billed for this service.

R. Department Policy Letters

The Contractor shall comply with policy letters issued by the Department to all Mental Health Plans as defined in Title 9, CCR, Section 1810.226. Policy letters will provide specific details of procedures established by the Department for performance of contract terms when procedures not covered in this agreement are determined to be necessary for performance under this agreement, but are not intended to change the basis and general terms of the contract.

S. Delegation

The Contractor shall ensure that any duties and obligations of the Contractor under this contract that are delegated to subcontracting entities meet the requirements of this contract and any applicable federal or state laws and regulations. The Contractor may delegate any duty or obligation under this contract unless delegation is specifically prohibited by this contract or by applicable federal or state laws and regulations. The Contractor may accept the certification of a provider by another Mental Health Plan or by the Department to meet the Contractor's obligations under Section L. The Department will hold the Contractor responsible for performance of the Contractor's duties and obligations under this contract whether or not the duty or obligation is delegated to a subcontractor or another Mental Health Plan.

T. Fair Hearings

The Contractor shall represent the Contractor's position in fair hearings (as defined in Title 9, CCR, Section 1810.216.1) dealing with beneficiaries' appeals of denials, modifications, deferrals or terminations of covered services. The

Contractor shall carry out the final decisions of the fair hearing process with respect to issues within the scope of the Contractor's responsibilities under this contract. Nothing in this section is intended to prevent the Contractor from pursuing any options available for appealing a fair hearing decision.

U. Crosswalk between Provider Coding System

The Contractor shall comply with Title 9, CCR, Section 1840.304 when submitting claims for federal financial participation for services billed by individual or group providers using service codes from the Health Care Financing Administration's Common Procedure Coding System (HCPCS). At such time as the table currently included in Section 1840.304 is deleted from this section, the Contractor shall follow the table issued by the Department as a DMH Information Notice.

V. Beneficiary Brochure and Provider Lists

The Contractor shall provide beneficiaries with a brochure upon request and when a beneficiary first receives a specialty mental health service from the Contractor or its subcontracting providers, including but not limited to an assessment to determine whether medical necessity criteria pursuant to Title 9, CCR, Section 1830.205 are met. The brochure shall contain a description of the services available; a description of the process for obtaining services, including the Contractor's statewide toll-free telephone number; the availability of a list of the Contractor's providers upon request; a description of the Contractor's beneficiary problem resolution process, including the complaint resolution and grievance processes; and a description of the beneficiary's right to request a fair hearing at any time before, during or within 90 days after the completion of the beneficiary problem resolution process. The description of the right to request a fair hearing shall include the information that a fair hearing may be requested whether or not the beneficiary uses the beneficiary problem resolution process and whether or not the beneficiary has received a notice of action pursuant to Title 9, CCR, Section 1850.210.

The Contractor shall provide beneficiaries with a list of the Contractor's providers upon request. The list shall include the providers' names and addresses and shall include information on the category of services available from each provider. At a minimum the services available from the provider must be categorized as psychiatric inpatient hospital services, targeted case management services and/or all other specialty mental health services. The list may include instructions to the beneficiary explaining how appointments may be scheduled.

W. Compliance with the Requirements of Emily Q v. Bonta

The Contractor shall comply with the provisions of the Final Judgment and Preliminary Injunction issued May 11, 2001, in the case of Emily Q. v. Bonta, Case No. CV 98-4181 AHM (AIJx), United States District Court, Central District of California, that apply to the Contractor as determined by the Department.

X. Reports Required by the Centers for Medicare and Medicaid Services (CMS)

The Contractor shall report to the Department no later than October 1, 2002, the number of children by category who voluntarily changed outpatient mental health providers during Fiscal Year 2001-02.

The Contractor shall report to the Department by October 1, 2002, the number of complaints raised to the Contractor through the Contractor's beneficiary problem resolution processes by category of children with special health care needs, by type of problem resolution process used (complaint process or grievance process) during Fiscal Year 2001-02. The report will include the issue and disposition of each complaint, unless more than 25 complaints were filed. If more than 25 complaints were filed, the report will include by the type of issues raised, the number filed under each type and the disposition by the following categories: granted in full, granted in part, denied.

Children with special health care needs are Medi-Cal beneficiaries under the age of 19 who meet the following criteria:

1. In Medi-Cal aid codes 20, 23, 24, 26, 27, 28, 6A, 60, 63, 64, 65, 66, 67, 68, 6C (Medi-Cal eligibility based on eligibility for Supplemental Security Income/Blind/Disabled)
2. In Medi-Cal aid codes 4K, 4C, 42, 5K, 40, 45 (Medi-Cal eligibility based on eligibility for Foster Care)
3. In Medi-Cal aid codes 03, 04 (Medi-Cal eligibility based on eligibility for Adoption Assistance programs)
4. In Medi-Cal aid codes 6V, 6W, 6X, 6Y (Medi-Cal beneficiaries enrolled in a Home and Community Based Services Model waiver)
5. Receiving services from the California Children's Services program as identified by the local CCS program, if the local CCS program is willing to provide the information, or by the beneficiary listing available to the Contractor on the Contractor's secured website at the Department. If both methods are available to the Contractor, the Contractor may select the identification method. If another method of identification becomes available, the Department will notify the Contractor through a letter to all county mental health directors.

Quality Improvement Program

A. The Mental Health Plan (MHP) will have a written Quality Improvement (QI) Program Description, in which structure and processes are clearly defined with responsibility assigned to appropriate individuals. The following elements will be included in the QI Program Description:

- The QI Program Description will be evaluated annually and updated as necessary
- The QI Program will be accountable to the MHP Director.
- A licensed mental health staff person will have substantial involvement in QI Program implementation.
- The MHP's practitioners, providers, consumers and family members will actively participate in the planning, design and execution of the QI Program.
- The role, structure, function and frequency of meetings of the QI Committee and other relevant committees will be specified.
    - The QI Committee will oversee and be involved in QI activities
    - The QI Committee will recommend policy decisions; review and evaluate the results of QI activities; institute needed QI actions; and ensure follow-up of QI processes
    - Dated and signed minutes will reflect all QI Committee decisions and actions
- The QI Program will coordinate with performance monitoring activities throughout the MHP, but not limited to, client and system outcomes, utilization management, credentialing, monitoring and resolution of beneficiary grievances and fair hearings and provider appeals, assessment of beneficiary and provider satisfaction, and clinical records review
- Contracts with hospitals and with individual, group and organizational providers will require:
    - cooperation with the MHP's QI Program, and
    - access to relevant clinical records to the extent permitted by State and Federal laws by the MHP and other relevant parties.

B. The QI Program will have an Annual QI Work Plan including the following:

- An annual evaluation of the overall effectiveness of the QI Program, demonstrating that QI activities have contributed to meaningful improvement in clinical care and beneficiary service, and describing completed and in-process QI activities:
- Monitoring of previously identified issues, including tracking of issues over time; and
- Objectives, scope, and planned activities for the coming year, including QI activities in each of the following areas:
    1. Monitoring the service delivery capacity of the MHP:
    - The MHP will implement mechanisms to assure the capacity of service delivery within the MHP
        - The MHP will describe the current number, types and geographic distribution of mental health services within its delivery system.

  - The MHP will set goals for the number, type, and geographic distribution of mental health services

2. Monitoring the accessibility of services:

- In addition to meeting Statewide standards, the MHP will set goals for:
  a. Timelines of routine mental health appointments;
  b. Timeliness of services for urgent conditions;
  c. Access to after-hours care; and
  d. Responsiveness of the MHP's 24 hour, toll free telephone number.
- The MHP will establish mechanisms to monitor the accessibility of mental health services, services for urgent conditions and the 24 hour, toll free telephone number

3. Monitoring beneficiary satisfaction

- The MHP will implement mechanisms to ensure beneficiary or family satisfaction.
- The MHP will assess beneficiary or family satisfaction by:
  - surveying beneficiary/family satisfaction with the MHP's services at least annually
  - evaluating beneficiary grievances and fair hearings at least annually; and
  - evaluating requests to change persons providing services at least annually
- The MHP will inform providers of the results of beneficiary/family satisfaction activities

4. Monitoring the MHP's service delivery system and meaningful clinical issues affecting beneficiaries, including the safety and effectiveness of medication practices.

- The scope and content of the QI Program will reflect the MHP's delivery system and meaningful clinical issues that affect its beneficiaries.
- Annually the MHP will identify meaningful clinical issues that are relevant to its beneficiaries for assessment and evaluation.
  - These clinical issues will include a review of the safety and effectiveness of medication practices. The review will be under the supervision of a person licensed to prescribe or dispense prescription drugs
  - In addition to medication practices, other clinical issue(s) will be identified by the MHP.
- The MHP will implement appropriate interventions when individual occurrences of potential poor quality are identified
- At a minimum the MHP will adopt or establish quantitative measures to assess performance and to identify and prioritize area(s) for improvement
- Providers, consumers and family members will evaluate the analyzed data to identify barriers to improvement that are related to clinical practice and/or administrative aspects of the delivery system

5. Monitoring continuity and coordination of care with physical health care providers and other human services agencies

- The MHP will work to ensure that services are coordinated with physical health care and other agencies used by its beneficiaries

- When appropriate, the MHP will exchange information in an effective and timely manner with other agencies used by its beneficiaries
- The MHP will monitor the effectiveness of its MOU with Physical Health Care Plans

6. Monitoring provider appeals

The following process will be followed for each of the QI work plan activities #1 - 6 identified above, to ensure the MHP monitoring the implementation of the QI Program. The MHP will follow the steps below for each of the QI activities:

1. collect and analyze data to measure against the goals, or prioritized areas of improvement that have been identified
2. identify opportunities for improvement and decide which opportunities to pursue
3. design and implement interventions to improve its performance
4. measure the effectiveness of the interventions

C. If the MHP delegates any QI activities, there will be evidence of oversight of the delegated activity by the MHP

- A written mutually agreed upon document will describe:
    - the responsibilities of the MHP and the delegated entity
    - the delegated activities
    - the frequency of reporting to the MHP
    - the process by which the MHP will evaluate the delegated entity's performance, and
    - the remedies, including revocation of the delegation, available to the MHP if the delegated entity does not fulfill its obligations

- Documentation will verify that the MHP:
    - evaluated the delegated entity's capacity to perform the delegated activities prior to delegation
    - approves the delegated entity's QI Program annually or as defined by contract terms
    - evaluates annually whether the delegated activities are being conducted in accordance with State and MHP Standards; and
    - has prioritized and addressed with the delegated entity those opportunities identified for improvement

Utilization Management Program

1. The MHP will have a written description of the Utilization Management (UM) program, in which structures and processes are clearly defined with responsibility assigned to appropriate individuals. The following elements will be included in the written UM program description:
   a) Licensed mental health staff will have substantial involvement in UM program implementation.
   b) A description of the authorization processes used by the MHP:
      i) Authorization decisions will be made by licensed or "waivered/registered" mental health staff consistent with State regulations.
      ii) Relevant clinical information will be obtained and used for authorization decisions. There will be a written description of the information that is collected to support authorization decision making.
      iii) The MHP will use the statewide medical necessity criteria to make authorization decisions.
      iv) The MHP will clearly document and communicate the reasons for each denial.
      v) The MHP will send written notification to its beneficiaries and providers of the reason for each denial.
   c) The MHP will provide the statewide medical necessity criteria to its providers, consumers, family members and others upon request.
   d) Authorization decisions will be made in accordance with the statewide timeliness standards for authorization of services for urgent conditions established in state regulation.
   e) The MHP will monitor the UM program to ensure it meets the established standards for authorization decision making, and take action to improve performance if it does not meet the established standards.
   f) The MHP will include information about the beneficiary grievance and fair hearing processes in all denial or modification notifications sent to the beneficiary.

2. The MHP will evaluate the UM program as follows:
   a) The UM program will be reviewed annually by the MHP, including a review of the consistency of the authorization process.
   b) If an authorization unit is used to authorize services, at least every two years, the MHP will gather information from beneficiaries and providers regarding their satisfaction with the UM program, and address identified sources of dissatisfaction.

3. If the MHP delegates any UM activities, there will be evidence of oversight of the delegated activity by the MHP.
   a) A written mutually agreed upon document will describe:
      i) The responsibilities of the MHP and the delegated entity
      ii) The delegated activities
      iii) The frequency of reporting to the MHP
      iv) The process by which the MHP evaluates the delegated entity's performance, and
      v) The remedies, including revocation of the delegation, available to the MHP if the delegated entity does not fulfill its obligations.

b) Documentation will verify that the MHP:

   i) Evaluated the delegated entity's capacity to perform the delegated activities prior to delegation

   ii) Approves the delegated entity's UM program annually

   iii) Evaluates annually whether the delegated activities are being conducted in accordance with the State and MHP standards, and

   iv) Has prioritized and addressed with the delegated entity those opportunities identified for improvement.

Documentation Standards For Client Records

The documentation standards are described below under key topics related to client care. All standards must be addressed in the client record; however, there is no requirement that the record have a specific document or section addressing these topics.

A. Assessments

1. The following areas will be included as appropriate as a part of a comprehensive client record.

- Relevant physical health conditions reported by the client will be prominently identified and updated as appropriate.
- Presenting problems and relevant conditions affecting the client's physical health and mental health status will be documented, for example: living situation, daily activities, and social support.
- Documentation will describe client strengths in achieving client plan goals.
- Special status situations that present a risk to client or others will be prominently documented and updated as appropriate.
- Documentation will include medications that have been prescribed by mental health plan physicians, dosages of each medication, dates of initial prescriptions and refills, and documentation of informed consent for medications.
- Client self report of allergies and adverse reactions to medications, or lack of known allergies/sensitivities will be clearly documented.
- A mental health history will be documented, including: previous treatment dates, providers, therapeutic interventions and responses, sources of clinical data, relevant family information and relevant results of relevant lab tests and consultation reports.
- For children and adolescents, pre-natal and perinatal events and complete developmental history will be documented.
- Documentation will include past and present use of tobacco, alcohol, and caffeine, as well as illicit, prescribed and over-the counter drugs.
- A relevant mental status examination will be documented.
- A five axis diagnosis from the most current DSM, or a diagnosis from the most current ICD, will be documented, consistent with the presenting problems, history, mental status evaluation and /or other assessment data.

2. Timeliness/Frequency Standard for Assessment

- The MHP will establish standards for timeliness and frequency for the above mentioned elements.

B. Client Plans

1. Client Plans will:

    - have specific observable and/or specific quantifiable goals
    - identify the proposed type(s) of intervention
    - have a proposed duration of intervention(s)
    - be signed (or electronic equivalent) by :
        - the person providing the service(s), or
        - a person representing a team or program providing services, or
        - a person representing the MHP providing services
        - when the client plan is used to establish that services are provided under the direction of an approved category of staff, and if the above staff are not of the approved category,
            - a physician
            - a licensed/"waivered" psychologist
            - a licensed/registered/waivered social worker
            - a licensed/registered/waivered marriage and family therapist or
            - a registered nurse

    - In addition,

        - client plans will be consistent with the diagnoses, and the focus of intervention will be consistent with the client plan goals, and there will be documentation of the client's participation in and agreement with the plan. Examples of documentation include, but are not limited to, reference to the client's participation and agreement in the body of the plan, client signature on the plan, or a description of the client's participation and agreement in progress notes.
            - client signature on the plan will be used as the means by which the MHP documents the participation of the client
                - when the client is a long term client as defined by the MHP, and
                - the client is receiving more than one type of service from the MHP
            - when the client's signature is required on the client plan and the client refuses or is unavailable for signature, the client plan will include a written explanation of the refusal or unavailability.
            - the MHP will give a copy of the client plan to the client on request.

2. Timeliness/Frequency of Client Plan:

    - Will be updated at least annually.
    - The MHP will establish standards for timeliness and frequency for the individual elements of the client plan described in item 1.

C. Progress Notes

1. Items that must be contained in the client record related to the client's progress in treatment include:

- The client record will provide timely documentation of relevant aspects of client care
- Mental health staff/practitioners will use client records to document client encounters, including relevant clinical decisions and interventions
- All entries in the client record will include the signature of the person providing the service (or electronic equivalent); the person's professional degree, licensure or job title; and the relevant identification number, if applicable
- All entries will include the date services were provided
- The record will be legible
- The client record will document referrals to community resources and other agencies, when appropriate
- The client record will document follow-up care, or as appropriate, a discharge summary

2. Timeliness/Frequency of Progress Notes:

Progress notes will be documented at the frequency by type of service indicated below:

a. Every Service Contact

- Mental Health Services
- Medical Support Services
- Crisis Intervention

b. Daily

- Crisis Residential
- Crisis Stabilization (1x/23hr)

c. Weekly

- Day Treatment Intensive
- Day Rehabilitation
- Adult Residential

d. Other

- Psychiatric health facility services: notes on each shift
- Targeted Case Management: every service contact, daily, or weekly summary
- As determined by the MHP for other services.

Provider Certification by the Contractor or the Department

As a part of the organizational provider certification requirements in Exhibit A, Attachment 1, Section K, and Exhibit E, Section 5, Item E, the Contractor and the Department respectively will verify, through an on-site review if required by those sections or if determined necessary by the Contractor or the Department respectively, that:

1. The organizational provider possesses the necessary license to operate, if applicable, and any required certification.
2. The space owned, leased or operated by the provider and used for services or staff meets local fire codes.
3. The physical plant of any site owned, leased, or operated by the provider and used for services or staff is clean, sanitary and in good repair.
4. The organizational provider establishes and implements maintenance policies for any site owned, leased, or operated by the provider and used for services or staff to ensure the safety and well being of beneficiaries and staff.
5. The organizational provider has a current administrative manual which includes: personnel policies and procedures, general operating procedures, service delivery policies, and procedures for reporting unusual occurrences relating to health and safety issues.
6. The organizational provider maintains client records in a manner that meets the requirements of the Contractor pursuant to Article V, Section G, and applicable state and federal standards.
7. The organizational provider has staffing adequate to allow the Contractor to claim federal financial participation for the services the organizational provider delivers to beneficiaries, as described in Division 1, Chapter 11, Subchapter 4 of Title 9, CCR, when applicable.
8. The organizational provider has written procedures for referring individuals to a psychiatrist when necessary, or to a physician, if a psychiatrist is not available.
9. The organizational provider has as head of service a licensed mental health professional or other appropriate individual as described in Title 9, CCR, Sections 622 through 630.
10. For organizational providers that provide or store medications, the provider stores and dispenses medications in compliance with all pertinent state and federal standards. In particular:
    A. All drugs obtained by prescription are labeled in compliance with federal and state laws. Prescription labels are altered only by persons legally authorized to do so.

B. Drugs intended for external use only or food stuffs are stored separately from drugs for internal use.

C. All drugs are stored at proper temperatures, room temperature drugs at 59-86 degrees F and refrigerated drugs at 36-46 degrees F.

D. Drugs are stored in a locked area with access limited to those medical personnel authorized to prescribe, dispense or administer medication.

E. Drugs are not retained after the expiration date. IM multi-dose vials are dated and initialed when opened.

F. A drug log is maintained to ensure the provider disposes of expired, contaminated, deteriorated and abandoned drugs in a manner consistent with state and federal laws.

G. Policies and procedures are in place for dispensing, administering and storing medications.

On-site review is not required for hospital outpatient hospital departments, which are operating under the license of the hospital. Services provided by hospital outpatient departments may be provided either on the premises or off-site.

On-site review is not required for primary care and psychological clinics licensed under Division 2, Chapter 1 of the Health and Safety Code. Services provided by the clinics may be provided either on the premises or off site in accordance with the conditions of their license.

When on site review of an organizational provider is required, the Contractor or the Department, as applicable, shall conduct an on-site review at least once every two years. Additional certification reviews of organizational providers may be conducted by the Contractor or Department, as applicable, at its discretion, if:

a) The provider makes major staffing changes.

b) The provider makes organizational and/or corporate structure changes (example: conversion from non-profit status.)

c) The provider adds day treatment or medication support services when medications will be administered or dispensed from the provider site.

d) There are significant changes in the physical plant of the provider site (some physical plant changes could require a new fire clearance).

e) There is a change of ownership or location.

f) There are complaints regarding the provider.

g) There are unusual events, accidents, or injuries requiring medical treatment for clients, staff or members of the community.

EXHIBIT B
PAYMENT PROVISIONS

1. The Department agrees to compensate the Contractor in accordance with the allocation amounts specified in Item 4 below under the conditions described in this Exhibit.

2. Budget Contingency Clauses

   A. Federal Budget: It is mutually agreed that, if the Congress does not appropriate sufficient funds for the program, the State has the option to void the contract or to amend the contract to reflect any reduction of funds. Such amendment will require Contractor approval.

   B. State Budget:

   It is mutually agreed that if the Budget Act of the current year does not appropriate sufficient funds for the program, this contract will be void and of no further force and effect. In such an event, the State will have no further liability to pay any funds whatsoever to the Contractor or to furnish any other considerations under this contract, and the Contractor will not be obligated to perform any provisions of this contract or to provide services intended to be funded pursuant to this contract.

   If funding for this contract is reduced or deleted by the Budget Act for the purposes of this program, the State shall have the option to either cancel this contract with no liability occurring to the State, or offer a contract amendment to the Contractor to reflect the reduced amount.

3. Prompt Payment Clause

   Payment will be made in accordance with, and within the time specified in Government Code, Chapter 45, commencing with Section 927.

4. Amounts Payable

   The total amount payable for the 2002-2003 Fiscal Year ending June 30, 2003 is $3,844,098.00. Of the total amount payable for the 2002-2003 Fiscal Year, $86,993.00 is additional state funds for covered services provided to beneficiaries residing in institutions for mental diseases. The amount payable is an interim amount only and is subject to the development of the allocation amount for the 2002-2003 Fiscal Year pursuant to Item 7. Any requirement of performance by the Department and the Contractor for this period will be dependent upon the availability of future appropriations by the Legislature for the purpose of this contract. The services shall be provided at the times required by this contract.

5. Payment to the Contractor

The Contractor will receive a single payment for the full amount payable under Section A for the fiscal year within 60 calendar days of the determination of the amount by the Department in accordance with Title 9, CCR, Section 1810.330, or the enactment of the State Budget for the fiscal year, whichever is later.

6. Payment in Full

The amount payable under Item 4, referred to hereafter as the allocation amount, constitutes payment in full by the Department of the State matching funds on behalf of beneficiaries for all covered services and for all utilization review and administrative costs incurred by the Contractor in providing or arranging for such services, except for the additional state matching funds for covered services to beneficiaries residing in institutions for mental diseases and for covered services, other than psychiatric inpatient hospital services, provided to beneficiaries under 21 years of age who are eligible for the full scope of Medi-Cal benefits.

The total amount payable in Item 4 includes an amount equal to state matching share of the historical cost of psychiatrist and psychologist services provided in the fee-for-service Medi-Cal program, which is not separately identified. The total amount payable also includes a separately identified amount in Item 4, which equals the federal matching funds for these costs. This amount is included to reflect the fact that federal funds are not available for these services. The separately identified amount for covered services to beneficiaries residing in institutions for mental diseases will be reviewed by the Department to ensure that the amount reasonably reflects the historical cost of psychiatrist and psychologist services provided in the fee-for-service Medi-Cal program. The amount payable under Item 4 for these services may be amended based on this review and the availability of state funds.

State matching funds, in addition to the amount payable under Item 4, for covered services, other than psychiatric inpatient hospital services, provided to beneficiaries under 21 years of age who are eligible for the full scope of Medi-Cal benefits will be paid in accordance with the Interagency Agreement between the Department and the State Department of Health Services (DHS 99-86346; DMH 99-79145-000 or subsequent agreement), which provides the federal financial participation and specified state matching funds for the Medi-Cal specialty mental health services and related activities

7. Determination of Allocation Amount

The allocation amount will be set annually on a formula basis as determined by the Department in consultation with a statewide organization representing counties pursuant to Section 5778, W&I Code.

8. Renegotiation or Adjustment of Allocation Amount

A. To the extent permitted by federal law, either the Department or the Contractor may request that contract negotiations of the allocation amount be reopened during the course of a contract due to substantial changes in the cost of covered services or related obligations that result from new legislative requirements affecting the scope of services or eligible population, or other unanticipated event. Any change in the allocation amount under this section is subject to the availability of funds. Any change in allocation amount will be retroactive to the effective date of the change authorizing the amendment.

B. The allocation amount may be changed pursuant to a change in the obligation of the Contractor as a result of a change in the obligations of a Medi-Cal managed care plan for services that would be covered by the Contractor if they were not covered by the Medi-Cal managed care plan, pursuant to Title 9, CCR, Section 1810.345 and Section 1810.350(a)(5). Any change in allocation amount will be retroactive to the effective date of the change authorizing the amendment.

9. Disallowance's and Offsets

1. In the event of disallowances or offsets as a result of federal audit exceptions, the provisions of Section 5778(h), W&I Code will apply.

2. The Department will offset the state matching funds for payments made by the Medi-Cal fiscal intermediary pursuant to Section 5778(g), W&I Code, against any funds held by the Department on behalf of the Contractor.

10. Federal Financial Participation

Nothing in this contract shall limit the Contractor from being reimbursed appropriate federal financial participation for any covered services or utilization review and administrative costs even if the total expenditure for services exceeds the contract amount.

EXHBIT D
SPECIAL PROVISIONS

1. Fulfillment of Obligation

No covenant, condition, duty, obligation, or undertaking continued or made a part of this contract will be waived except by written agreement of the parties hereto, and forbearance or indulgence in any other form or manner by either party in any regard whatsoever will not constitute a waiver of the covenant, condition, duty, obligation, or undertaking to be kept, performed or discharged by the party to which the same may apply; and, until performance or satisfaction of all covenants, conditions, duties, obligations, and undertakings is complete, the other party will have the right to invoke any remedy available under this contract, or under law, notwithstanding such forbearance or indulgence.

2. Amendment of Contract

Should either party during the life of this contract desire a change in this contract, such change will be proposed in writing to the other party. The other party will acknowledge receipt of the proposal within 10 days and will have 60 days after receipt of such proposal to review and consider the proposal, to consult and negotiate with the proposing party, and to accept or reject the proposal. Acceptance or rejection may be made orally within said 60-day period, and confirmed in writing within five days thereafter. The party proposing any such change will have the right to withdraw the proposal any time prior to acceptance or rejection by the other party. Any such proposal will set forth a detailed explanation of the reason and basis for the proposed change, a complete statement of cost and benefits of the proposed change and the text of the desired amendment to this contract which would provide for the change. If the proposal is accepted, this contract will be amended to provide for the change mutually agreed to by the parties on the condition that the amendment is approved by the Department of General Services, if necessary.

3. Contract Disputes

Should a dispute arise between the Contractor and the Department relating to performance under this contract other than disputes governed by a dispute resolution process in Chapter 11 of Division 1, Title 9, CCR, the Contractor will, prior to exercising any other remedy which may be available, provide the Department with written notice of the particulars of the dispute within 30 calendar days of the dispute. The Department will meet with the Contractor, review the factors in the dispute, and recommend a means of resolving the dispute before a written response is given to the Contractor. The Department will provide a written response to the Contractor within 30 days of receipt of the Contractor's written notice.

4. Inspection Rights

The Contractor will allow the Department, HHS, the Comptroller General of the United States, and other authorized federal and state agencies, or their duly authorized representatives, to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services performed under this contract, and to inspect, evaluate, and audit any and all books, records, and facilities maintained by the Contractor and subcontractors, pertaining to such services at any time during normal business hours. Books and records include, but are not limited to, all physical records originated or prepared pursuant to the performance under this contract including working papers, reports, financial records and books of account, beneficiary records, prescription files, subcontracts, and any other documentation pertaining to covered services and other related services for beneficiaries. Upon request, at any time during the period of this contract, the Contractor will furnish any such record, or copy thereof, to the Department or HHS. Authorized agencies will maintain the confidentiality of such books and records in accordance with applicable laws and regulations.

5. Notices

All notices to be given under this contract will be in writing and will be deemed to have been given when mailed, to the Department or the Contractor at the following addresses:

State Dept. of Mental Health Srvs
Technical Assistance and Training
Systems of Care Division
1600 Ninth Street, Room 100
Sacramento, CA 95814

San Francisco County Mental Health
Jo Ruffin, Director
1380 Howard Street, 5th Floor
San Francisco, CA 94103

6. Confidentiality

A. The parties to this agreement will comply with applicable laws and regulations, including but not limited to Section 5328 et seq. and

Section 14100.2 of the W&I Code and Title 42, CFR, Section 431.300 et seq. regarding the confidentiality of beneficiary information.

B. The Contractor will protect from unauthorized disclosure, names and other identifying information concerning beneficiaries receiving services pursuant to this contract except for statistical information. The Contractor will not use identifying information for any purpose other than carrying out the Contractor's obligations under this contract.

C. The Contractor will not disclose, except as otherwise specifically permitted by state and federal laws and regulation or this contract or authorized by the beneficiary, any such identifying information to anyone other than the State without prior written authorization from the State in accordance with state and federal laws.

D. For purposes of the above paragraphs, identifying information will include, but not be limited to: name, identifying number, symbol, or other identifying particular assigned to the individual.

7. Nondiscrimination

A. Consistent with the requirements of applicable federal or state law, the Contractor will not engage in any unlawful discriminatory practices in the admission of beneficiaries, assignments of accommodations, treatment, evaluation, employment of personnel, or in any other respect on the basis of race, color, gender, religion, marital status, national origin, age, sexual preference or mental or physical handicap.

B. The Contractor will comply with the provisions of Section 504 of the Rehabilitation Act of 1973, as amended, pertaining to the prohibition of discrimination against qualified handicapped persons in all federally assisted programs or activities, as detailed in regulations signed by the Secretary of Health and Human Services, effective June 2, 1977, and found in the Federal Register, Volume 42, No. 86, dated May 4, 1977.

C. The Contractor will include the nondiscrimination and compliance provisions of this contract in all subcontracts to perform work under this contract.

D. Notwithstanding other provisions of this section, the Contractor may require a determination of medical necessity pursuant to Title 9, CCR, Section 1820.205, Section 1830.205 or Section 1830.210, prior to providing covered services to a beneficiary.

8. Patients' Rights

The parties to this contract will comply with applicable laws, regulations and State policies relating to patients' rights.

9. Relationship of the Parties

The Department and the Contractor are, and will at all times be deemed to be, independent agencies. Each party to this agreement will be wholly responsible for the manner in which it performs the obligations and services required of it by the terms of this agreement. Nothing herein contained will be construed as creating the relationship of employer and employee, or principal and agent, between the parties or any of their agents or employees. Each party assumes exclusively the responsibility for the acts of its employees or agents as they relate to the services to be provided during the course and scope of their employment. The Department, its agents and employees, will not be entitled to any rights or privileges of Contractor employees and will not be considered in any manner to be Contractor employees. The Contractor, its agents and employees, will not be entitled to any rights or privileges of state employees and will not be considered in any manner to be state employees.

10. Waiver of Default

Waiver of any default will not be deemed to be a waiver of any subsequent default. Waiver of breach of any provision of this agreement will not be deemed to be a waiver of any other or subsequent breach, and will not be construed to be a modification of the terms of this contract.

EXHIBIT E
ADDITIONAL PROVISIONS

SECTION 1 – GENERAL AUTHORITY

This contract is entered into in accordance with the provisions of Part 2.5 (commencing with Section 5775) of Division 5 of the Welfare and Institutions (W&I) Code.

Part 2.5 (commencing with Section 5775) of Division 5 of the W&I Code directs the State Department of Mental Health to implement and administer Managed Mental Health Care for Medi-Cal eligible residents of this state; and San Francisco County Mental Health desires to operate the Mental Health Plan for San Francisco County.

SECTION 2 – DEFINITIONS

Unless otherwise expressly provided or the context otherwise requires, the following definitions of terms will govern the construction of this contract:

A. "Beneficiary" means any Medi-Cal beneficiary whose county of responsibility on the Medi-Cal Eligibility Data System (MEDS) or as determined pursuant to Title 9, California Code of Regulations (CCR), Section 1850.405, corresponds with the county covered by this contract.

B. "Contractor" means San Francisco County Mental Health.

C. "Covered Services" means specialty mental health services as defined in Title 9, CCR, Section 1810.247, to the extent described in Title 9, CCR, Section 1810.345, except that psychiatric nursing facility services are not included.

D. "Department" means the State Department of Mental Health.

E. "Director" means the Director of the State Department of Mental Health.

F. "HHS" means the United States Department of Health and Human Services.

G. "Emergency Psychiatric Condition" means that a beneficiary has a condition that meets admission reimbursement criteria for medical necessity according to Title 9, CCR, Section 1820.205, and due to a mental disorder, is:

1. A danger to self or others, or

2. Immediately unable to provide for or utilize food, shelter or clothing.

H. "Facility" means any premises:

1. Owned, leased, used or operated directly or indirectly by or for the Contractor or its affiliates for purposes related to this contract, or

2. Maintained by a provider to provide covered services on behalf of the Contractor.

I. "Individual provider" means a provider as defined in Title 9, CCR, Section 1810.222.

J. "Group provider" means a provider as defined in Title 9, CCR, Section 1810.218.2.

K. "Medi-Cal managed care plan" means an entity contracting with the State Department of Health Services to provide services to enrolled beneficiaries under Chapter 7, commencing with Section 14000, or Chapter 8, commencing with Section 14200, of Division 9, Part 3 of the W&I Code.

L. "Organizational provider" means a provider as defined in Title 9, CCR, Section 1810.231.

M. "Psychiatric nursing facility services" means services as defined in Title 9, CCR, Section 1810.239.

N. "Public school site" means a location on the grounds of a public school at which a provider delivers specialty mental health services to beneficiaries.

O. "Satellite site" means a site owned, leased or operated by an organizational provider at which specialty mental health services are delivered to beneficiaries less than 20 hours per week, or, if located at a multiagency site, at which specialty mental health services are delivered by no more than two employees or contractors of the provider.

P. "Subcontract" means an agreement entered into by the Contractor with any of the following:

1. A provider of specialty mental health services who agrees to furnish covered services to beneficiaries.
2. Any other organization or person who agrees to perform any administrative function or service for the Contractor specifically related to securing or fulfilling the Contractor's obligations to the Department under the terms of this contract.

Q. "Urgent condition" means a situation experienced by a beneficiary that without timely intervention is likely to result in an immediate emergency psychiatric condition.

SECTION 3 – GENERAL PROVISIONS

A. Governing Authorities

This contract will be governed by and construed in accordance with:

Part 2.5 (commencing with Section 5775), Chapter 4, Division 5, W&I Code;

Article 5 (Sections 14680- 14685), Chapter 8.8, Division 9, W&I Code;

Chapter 11 (commencing with Section 1810.100), Title 9, CCR.

Title 42, Code of Federal Regulations (CFR);

Title 42, United States Code;

All other applicable laws and regulations.

The terms and conditions of any Interagency Agreement between the Department of Mental Health and the Department of Health Services related to the provision of mental health services to beneficiaries by the Contractor.

Any provision of this contract which is subsequently determined to be in conflict with the above laws, regulations, and agreements is hereby amended to conform to the provisions of those laws and regulations. Such amendment of the contract will be effective on the effective date of the statutes, regulations or agreements necessitating it, and will be binding on the parties hereto even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties. Such amendment will constitute grounds for termination of this contract, in accordance with the provisions of Article IV and Title 9, CCR, Section 1810.325(d), if the Contractor determines it is unable or unwilling to comply with the provisions of such amendment. If the Contractor gives notice of termination to the Department, the parties will not be bound by the terms of such amendment, commencing from the time notice of termination is received by the Department until the effective date of termination.

SECTION 4 – TERM AND TERMINATION

A. Contract Renewal

This contract may be renewed unless good cause is shown for nonrenewal pursuant to Title 9, CCR, Section 1810.320. Renewal will be on an annual basis.

B. Contract Termination

The Department or the Contractor may terminate this contract in accordance with Title 9, CCR, Section 1810.325.

C. Mandatory Termination

The Department shall immediately terminate this contract in the event that the Director determines that there is an immediate threat to the health and safety of beneficiaries. The department shall terminate this contract in the event that the Secretary, HHS, determines that the contract does not meet the requirements for participation in the Medicaid program, Title XIX of the Social Security Act. Terminations under this section will be in accordance with Title 9, CCR, Section 1810.325.

D. Termination of Obligations

All obligations to provide covered services under this contract will automatically terminate on the effective date of any termination of this contract. The Contractor will be responsible for providing covered services to beneficiaries until the termination or expiration of the contract and will remain liable for the processing and payment of invoices and statements for covered services provided to beneficiaries prior to such expiration or termination.

SECTION 5 – DUTIES OF THE STATE

In discharging its obligations under this contract, the State will perform the following duties:

A. Payment for Services

Pay the appropriate payments set forth in Exhibit B.

B. Reviews

Conduct reviews of access and quality of care at least once every 12 months and issue reports to the Contractor detailing findings, recommendations, and corrective action, as appropriate.

C. Monitoring for Compliance

Monitor the operation of the Contractor for compliance with the provisions of this contract, and applicable federal and state law and regulations. Such monitoring activities will include, but not be limited to, inspection and auditing of Contractor facilities, management systems and procedures, and books and records as the Department deems appropriate, at any time during the Contractor's or facility's normal business hours.

D. Approval Process

1. In the event that the Contractor requests changes to its Implementation Plan, the Department will provide a Notice of Approval or Notice of Disapproval including the reasons for the disapproval, to the Contractor within 30 calendar days after the receipt of the request from the Contractor. The Contractor may implement the proposed changes 30 calendar days from submission to the Department, if the Department fails to provide a Notice of Approval or Disapproval.

2. The Department will act promptly to review the Contractor's Cultural Competence Plan submitted pursuant to Exhibit A, Attachment 1, Item K. The Department will provide a Notice of Approval or a Notice of Disapproval including the reasons for the disapproval, to the Contractor within 60 calendar days after the receipt of the plan from the Contractor. The Contractor may implement the plan 60 calendar days from submission to the Department if the Department fails to provide a Notice of Approval or Disapproval.

3. The Department will act promptly to review requests from the Contractor for approval of subcontracts with providers that meet the conditions described in Title 9, CCR, Section 1810.438. The Department will act to approve or disapprove the reimbursement and related claiming and cost reporting issues included in the subcontract within 60 days of receipt of a request from the Contractor. If the Department disapproves the request, the Department will provide the Contractor with the reasons for disapproval.

E. Certification of Organizational Provider Sites Owned or Operated by the Contractor

The Department will certify the organizational provider sites that are owned, leased or operated by the Contractor, in accordance with Title 9, CCR, Section 1810.435 and the requirements specified in Exhibit A, Attachment 1, Appendix D. This certification shall be prior to the date on which the Contractor begins to deliver services under this contract at these sites and once every two years after that date, unless the Department determines an earlier date is necessary. The on-site review required by Title 9, CCR, Section 1810.435(e), will be made of any site owned, leased, or operated by the Contractor and used for to deliver covered services to beneficiaries, except that on-site review is not required for public school or satellite sites.

If the Department has performed a similar certification of the Contractor's organizational provider sites for participation in the Short-Doyle/Medi-Cal program, certification by the Department is not required prior to the date on which the Contractor begins to deliver services under this contract at these sites.

The Department may allow the Contractor to begin delivering covered services to beneficiaries at a site subject to on-site review by the Department prior to the date of the on-site review, provided the site is operational and has any required fire clearances. The earliest date the Contractor may begin delivering covered services at a site subject to on site review by the Department is latest of the date the Contractor requested certification of the site in accordance with procedures established by the Department, the date the site was operational, or the date a required fire clearance was obtained.

The Department may allow the Contractor to continue delivering covered services to beneficiaries at a site subject to on-site review by the Department as part of the biennial recertification process prior to the date of the on-site review, provided the site is operational and has any required fire clearances.

Nothing in this section precludes the Department from establishing procedures for issuance of separate provider identification numbers for each of the organizational provider sites operated by the Contractor to facilitate the claiming of federal financial participation by the Contractor and the Department's tracking of that information.

F. Sanctions

Apply oversight and sanctions in accordance with Title 9, CCR, Sections 1810.380 and 1810.385, to the Contractor for violations of the terms of this contract, and applicable federal and state law and regulations.

G. Notification

Notify beneficiaries of their Medi-Cal specialty mental health benefits and options available upon termination or expiration of this contract.

SECTION 6 – SUBCONTRACTS

A. No subcontract terminates the legal responsibility of the Contractor to the Department to assure that all activities under the contract are carried out.

B. All subcontracts must be in writing except those for seldom-used or unusual goods and services.

C. All inpatient subcontracts must require that subcontractors maintain necessary licensing and certification.

D. Each subcontract must contain:

a. Full disclosure of the method and amount of compensation or other consideration to be received by the subcontractor from the Contractor.

b. Specification of the services to be provided.

c. Specification that the subcontract will be governed by and construed in accordance with all laws, regulations, and contractual obligations of the Contractor under this contract.

d. Specification of the term of the subcontract including the beginning and ending dates as well as methods for amendment, termination and, if applicable, extension of the subcontract.

e. The nondiscrimination and compliance provisions of this contract as described in Article III, Section I.

f. Subcontractor's agreement to submit reports as required by the Contractor.

g. The subcontractor's agreement to make all of its books and records, pertaining to the goods and services furnished under the terms of the subcontract, available for inspection, examination or copying by the Department, HHS, the Comptroller General of the United States, and other authorized federal and state agencies, or their duly authorized representatives, at all reasonable times at the subcontractor's place of business or at such other mutually agreeable location in California, in a form maintained in accordance with the general standards applicable to such book or record keeping, for a term of at least five years from the close of the Department's fiscal year in which the subcontract was in effect.

h. Subcontractor's agreement that assignment or delegation of the subcontract will be void unless prior written approval is obtained from the Contractor.

i. Subcontractor's agreement to hold harmless both the State and beneficiaries in the event the Contractor cannot or will not pay for services performed by the subcontractor pursuant to the subcontract.

SAN FRANCISCO MENTAL HEALTH BOARD

1380 Howard Street, Suite 510
San Francisco, CA 94103
(415) 255-3474 fax: 255-3760
mhb@igc.org
www.sfgov.org/mental_health

MENTAL HEALTH BOARD
ATTACHMENT D
September 11, 2002

REVIEW OF THE SAMHSA APPLICATION

The Mental Health Board is required every year to review the renewal application of the Community Mental Health Services grant from the Substance Abuse and Mental Health Services Administration (SAMHSA).

PROPOSED RESOLUTION

Be it resolved that the Mental Health Board send a letter to Robert Cabaj, M.D., Director, Community Mental Health Services and Community Behavioral Health Services, stating that the Board has reviewed the federal SAMHSA (Substance Abuse and Mental Health Services Administration) renewal application for fiscal year 2002/03 funds and that the Board gives its full approval and support to this grant.

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City and County of San Francisco
Department of Public Health
Community Mental Health Services

Robert Cabaj, MD
Acting Mental Health Director
1380 Howard Street, 5th Floor
San Francisco, CA 94103
415.255.3447 Fax: 415.252.3015
E-mail: bob_cabaj@dph.sf.ca.us

August 29, 2002

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Ms. Linda Powell
Deputy Director
Administrative Services
Department of Mental Health
Planning, Grants & Revenue Enhancement
1600 9th Street, Room 130
Sacramento, CA 95814

Dear Ms. Powell,

Attached is San Francisco's Fiscal Year '02-'03 SAMHSA renewal application for Block Grant funds in the amount of $3,580,151. This amount includes the proposed base allocation amount of 1,939,394, Dual Diagnosis set aside of $685,821 and the carry forward amount of $954,936.

Documentation regarding the review of this application by the Mental Health Board and will be sent under separate cover.

Please call Tina Yee (415) 255-3422 if you have any questions about this application.

Sincerely,

Linda Wang, LCSW for

Robert Cabaj, MD

cc: Espie Biasbas
Lucille Burlew-Lawler

RC:aem
Attachments

SAMSHA BLOCK GRANT RENEWAL APPLICATION

San Francisco

FY 2002-2003

1. Board of Supervisors Resolution

FILE NO. 021231 RESOLUTION NO. 553-02

[Recurring FY2002-2003 State grant funds to the Department of Public Health from the California Department of Health Services.]

Resolution authorizing the acceptance and expenditure of State grant funds by the San Francisco Department of Public Health for FY 2002-2003.

WHEREAS, The San Francisco Administrative Code requires City departments to obtain Board of Supervisors' approval in order to accept or expend any grant funds (Section 10.170 et seq.); and,

WHEREAS, The Board of Supervisors provided in Section 11.1 of the administrative provisions of the FY2002-2003 Annual Appropriation Ordinance that approval of recurring grant funds contained in departmental budget submissions and approved in the FY2002-2003 budget are deemed to meet the requirements of the San Francisco Administrative Code regarding grant approvals; and,

WHEREAS, The agencies of the State of California that provide grant funds to the San Francisco Department of Public Health require the Department to provide documentation of the Board's approval of their specific grant funds (State Administrative Manual Section 1208.2 (a)); and,

WHEREAS, The City's budget for FY2002-03 does not list each State grant but contains two aggregate items, one indicating all Federal and one all State grant funds; and,

WHEREAS, The Department of Public Health has prepared a document entitled "Recurring FY 2002-2003 State Grants, Schedule A" that lists the estimated amount of each recurring grant provided by the State of California for FY2002-2003, the State agency that provides the grant, and the indirect costs of each grant, which is attached to this Resolution and is included in the Board of Supervisors File No. 021231 ; and, WHEREAS, As a result of periodic redistribution of appropriations within the State budget, the Department of Public Health may, in fact, receive more money or less money from some of the various grants itemized in the attached document than the Department of Public Health estimates at this time; now, therefore, be it

RESOLVED, That the Board of Supervisors hereby approves the acceptance and expenditure by the San Francisco Department of Public Health of the State of California grants listed in the attached document, "Recurring FY 2002-2003 State Grants, Schedule A"; and, be it

FURTHER RESOLVED, That should the Department of Public Health receive more money or less money on any of the grants than is estimated in the attached document, that the Board of Supervisors hereby approves the acceptance and expenditure by the San Francisco Department of Public health of that additional or reduced money.

Recommended:

Mitchell H. Katz, M.D.
Director of Health

Julia Kelly for
Michele M. Olson
Health Commission

City and County of San Francisco

Tails

Resolution

City Hall
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102-4689

File Number: 021231 **Date Passed:**

Resolution authorizing the acceptance and expenditure of State grant funds by the San Francisco Department of Public Health for FY 2002-2003.

August 12, 2002 Board of Supervisors — ADOPTED

Ayes: 11 - Ammiano, Daly, Gonzalez, Hall, Leno, Maxwell, McGoldrick, Newsom, Peskin, Sandoval, Yee

File No. 021231

I hereby certify that the foregoing Resolution was ADOPTED on August 12, 2002 by the Board of Supervisors of the City and County of San Francisco.

Gloria L. Young

Gloria L. Young by Kay Gulbengay
Clerk of the Board

AUG 23 2002

Date Approved

Mayor Willie L. Brown Jr.

CITY COUNTY OF SAN FRANCISCO
DEPARTMENT OF PUBLIC HEALTH
RECURRING FY 2002-2003 STATE GRANTS, SCHEDULE A

Program/ Sub-Program	Agency	State Contract. #	FY 02-03 Grant Term	FY-02-03 Grant Amt.	FY-02-03 Indirect Costs	Indirect Cost Information	Title, Services, FY 2002-03
PHP AIDS	State	01-15096/EIPPOCO1-38	7/1/02-6/30/03	$870,000	-$0-	N/A	Early Intervention/Primary Care
							Services to prevent /delay progression of disease and transmission of infection.
PHP CHS	Federal pass-through to State	00-91687	4/1/02-3/31/03	$1,447,223	-$0-	N/A	CARE Title II
							Comprehensive AIDS resources for emergency disaster relief.
PHP AIDS	State	01-15096/E&P 01-38	7/1/02-6/30/03	$1,564,004	$62,597	15% of total personnel costs	AIDS Education and Prevention Coordination, quality assurance and HIV/AIDS education services to targeted populations.
PHP AIDS	State	01-15096/HIV 01-38	7/1/02-6/30/03	$832,333	-$0-	N/A	HIV Testing Program Anonymous and confidential HIV testing services.
PHP AIDS	State	01-15096/SP 01-38	7/1/02-6/30/03	$341,000	-$0-	N/A	AIDS Surveillance (Local Assistance Block Grant)
							Establish and expand active AIDS case surveillance.
PHP AIDS	State	01-15096/CORR 01-38	7/1/02-6/30/03	$2,079,969	-$0-	N/A	HIV/AIDS Intervention, Prevention, and Continuity of Care Demonstration Projects for Incarcerated Individuals
							Comprehensive AIDS services for incarcerated individuals.
PHP AIDS	State	Standard Agmt 6/27/01	7/1/02-6/30/03	$149,069	-$0-	N/A	AIDS Drug Assistance Program
							Local administration of enrollment screening/recertification process.
PHP AIDS	State	01-15096/YMS 01-38	7/1/02-6/30/03	$105,000	-$0-	N/A	Young Men's Survey
							Study of prevalence of HIV, STD, hepatitis and related risk behaviors.
PHP CHS	State	99-85747	10/1/02-9/30/03	$1,811,137	-$0-	N/A	WIC Program
							Nutrition services to women and infants and children under age five.
CHS MCH	State	01-15652	10/1/02-9/30/03	$233,947	$8,859	6% of total personnel	Nutrition Network Project
							To promote healthy eating and a physically active lifestyle.

CITY COUNTY OF SAN FRANCISCO
DEPARTMENT OF PUBLIC HEALTH
RECURRING FY 2002-2003 STATE GRANTS, SCHEDULE A

Program/ Sub-Program	Agency	State Contract. #	FY 02-03 Grant Term	FY-02-03 Grant Amt.	FY-02-03 Indirect Costs	Indirect Cost Information	Title, Services, FY 2002-03
CHS MCH	State	01-15760	10/1/02-9/30/03	$60,000	$2,115	5% of salaries	Project LEAN
							To support Nutrition Network activities and implement a community-based social marketing plan.
CHS MCH	State	200138	7/1/02-6/30/03	$861,688	$81,542	10% of salaries	Perinatal, MCH Allotment
							Coordination and advocacy for programs and services targeting women and children. Prenatal care guidance, and toll-free line.
CHS MCH	Federal pass-through to State	2000-2001	7/1/02-6/30/03	$2,111,289	$236,579	21.87% of salaries	CHDP - EPSDT
							Child health and disability prevention services.
CHS MCH	State	200138	7/1/02-6/30/03	$549,398	$13,053	10% of salaries	Black Infant Health
							Education, support, and case management to African-American pregnant women and their infants. City wide task force.
CHS MCH	State	98-15282	7/1/02-6/30/03	$43,500	$2,643	10% of salaries	Teen Smart Outreach Outreach and counseling services to adolescents, with Maxine Hall Health Center.
PHP CHS	Federal pass-through to State	Letter	7/1/02-6/30/03	$420,615	$20,627	6.5% of salaries	Health Care Program for Children in Foster Care Increase public health nursing time to meet the needs of children in foster care.
CHS BEHM	State	00-90453	7/1/02-6/30/03	$629,858	$51,308	10% of personnel costs	Childhood Lead Prevention Program and Lead Medi-Cal Allocation
							Identifying and managing cases of children with elevated levels of lead in blood.
PHP CH&SS	State		7/1/02-6/30/03	$362,993	$2,368	.6566% of mod.direct costs	Removing Barriers to Effective Asthma Management
							Services for infants, toddlers and children up to 5 years of age.
PHP CHPP	State	01-15362	7/1/02-6/30/03	$30,429	$2,024	23.1 % of salaries	Dental Education Services
							Education, screening, and follow up services for preschool and elementary school children.

CITY COUNTY OF SAN FRANCISCO
DEPARTMENT OF PUBLIC HEALTH
RECURRING FY 2002-2003 STATE GRANTS, SCHEDULE A

Program/ Sub-Program	Agency	State Contract #	FY 02-03 Grant Term	FY-02-03 Grant Amt.	FY-02-03 Indirect Costs	Indirect Cost Information	Title, Services, FY 2002-03
CHS CHPP	State	TCS-01-38	7/1/02-6/30/03	$588,322	$18,890	15% of salaries	AB 75 Health Education Tobacco Tax-Tobacco Free Project
							Provide tobacco education in accordance with the State Comprehensive Tobacco Control Plan.
PHP CHPP	State	97-11744-02	10/1/02-9/30/03	$708,100	-$0-	N/A	Breast and Cervical Cancer Control Program (BCCCP)
							Screening, diagnostic, and case-management services and follow-up for low-income women.
PHP CHPP	State	00-90-9460-1	10/1/02-9/30/03	$178,000	-$0-	N/A	CDC Basic Refugee Program
							TB/ communicable disease control, health education and counseling services to refugees.
PHP CHPP	State	00-90-9460-1	10/1/02-9/30/03	$66,749	-$0-	N/A	Immigrant Public Health
							Immigrant Public Health services and refugee preventive health services.
PHP CHPP	State	00-90735	7/1/02-6/30/03	$150,000	$5,961	12% of personnel costs	Children & Youth Domestic Violence Free Expand domestic violence prevention in San Francisco.
CHS CHPP	Federal pass-through to State	PS0029	10/1/02-8/31/03	$272,179	$23,973	15% of personnel costs	San Francisco Pedestrian Safety Comprehensive pedestrian injury surveillance system.
CHS CHPP	State	CBO111	10/1/02-9/30/03	$250,097	$10,458	15% of personnel costs	San Francisco CBO Traffic and Pedestrian Safety Establish a city-wide mini-grant program to promote community-based solutions to traffic safety problems in a variety of settings.
CHN	Federal pass-through to State		7/1/02-6/30/03	$202,660	$3,326	2% of direct costs	McKinney Homeless PATH Mental health services for mentally ill who are homeless or at risk of becoming homeless.
PHP CHS	State	01-71039-000	7/1/02-6/30/03	$100,000	$2,000	2% of direct costs	Continuum HIV Day Support Services
							Adult Day Care services to people with HIV/AIDS.

CITY COUNTY OF SAN FRANCISCO
DEPARTMENT OF PUBLIC HEALTH
RECURRING FY 2002-2003 STATE GRANTS, SCHEDULE A

Program/ Sub-Program	Agency	State Contract. #	FY 02-03 Grant Term	FY-02-03 Grant Amt.	FY-02-03 Indirect Costs	Indirect Cost Information	Title, Services, FY 2002-03
PHP CHS	State	01-71039-000	7/1/02-6/30/03	$164,000	3,280	2.04% of direct costs	AIDS Dementia & Residential Support Services
							AIDS/ARC/HIV mental health residential and adult day services at the Peter Claver Community (Catholic Charities).
DPH CMHS	Federal pass-through to State	CFDA 93.958	7/1/02-6/30/03	$514,769	-$0-	N/A	SAMHSA - System of Care/Family Mosaic
							Services to seriously mentally ill adults, older adults, and seriously emotionally disturbed children and youth.
PHP CSAS	State	DCP-01-38-03	7/1/02-6/30/03	$379,257	-$0-	N/A	Drug Court Partnership Program. Outpatient and residential services; ancillary services such as life skill training and housing services.
PHP CSAS	State	CDCI-01/02-38-02	12/29/02-12/28/03	$221,532	-$0-	N/A	Comprehensive Drug Court Implementation Project Assist the SF County Juvenile Drug Court Program,Youth Treatment and Education to enhance existing sevices and expand capacity.
CH&SS BEHM	State	0-013-550-0	7/1/02-6/30/03	$539,242	$66,862	16% of personnel	LUST-LOP Project
							Local oversight of cleanup activities at leaking underground storage tank sites.
CH&SS BEHM	State	EA11-01-4962	6/30/02-8/30/03	$22,000	-$0-	N/A	Solid Waste Permit and Inspection Program Funds to permit local enforcement agencies to acquire additional resources.
CH&SS BEHM	State	POO75022	1/1/03-12/31/03	$5,000	$722	22% of salaries	Oil Spill Prevention and Response Input in development of SF Bay/San Joaquin Delta Area.
PHP CH&SS	State	01-15224	7/1/02-6/30/03	$458,778	$2,000	5% of CHS contracts not to exceed $1,000 each	Immunization Services and Collaborative Immunization Project Grant
							Prevention, surveillance and outbreak control against nine vaccine preventable diseases and petinatal Hepatitis B services.
PHP CH&SS	State	Standard Agreement	10/1/02-9/30/03	$23,210	-$0-	N/A	Public Health Preparedness and Response to Bioterrorism
							Partially fund the City's Metropolitan Medical Response System to respond to the threat of bioterrorism and biological warfare.

CITY COUNTY OF SAN FRANCISCO
DEPARTMENT OF PUBLIC HEALTH
RECURRING FY 2002-2003 STATE GRANTS, SCHEDULE A

Program/ Sub-Program	Agency	State Contract. #	FY 02-03 Grant Term	FY-02-03 Grant Amt.	FY-02-03 Indirect Costs	Indirect Cost Information	Title, Services, FY 2002-03
PHP CH&SS	State	98-16028 A01	4/1/02-3/31/03	$135,696	$12,336	10% of personnel	STD Training Program
							STD training for health providers In San Francisco and surrounding Bay Area counties.
PHP CH&SS	State	01-15956	7/1/02-6/30/03	$400,000	-$0-	N/A	Viral Load Testing HIV-1 Provide HIV -1 viral load tests to monitor efficacy of treatment in HIV-Infected individuals and monitor infection.
PHP CH&SS	State		7/1/02-6/30/03	$447,161	-$0-	N/A	Tuberculosis Subvention
							TB control and prevention and outreach and the Directly Observed Therapy Program for tuberculosis patients.
Central Admin	Federal pass-through to State	Letter	10/1/02-9/30/03	$18,058	$1,806	11.11% of direct costs	CDH 314(d) Fund. Federal Preventive Health and Health Services Block Grant.
PHP CHS	Federal pass-through to State	OP9913	10/1/02-3/31/03	$334,028	$13,902	15% of personnel costs	Child Passenger Safety Develop and implement a comprehensive child passenger safety program.
PHP EMS	State	EMS-1082	7/1/02-6/30/03	$912,440	-$0-	N/A	Trauma Care Fund Promote access to trauma care by supporting SFGH Trauma Center.
DPH CMHS	State		7/1/02-6/30/03	$50,000	-$0-	N/A	Infant Preschool Family Mental Health Unit for services to children from birth to 5 and their families.
DPH CMHS	Federal pass-through to State	CFDA 93.958	7/1/02-6/30/03	$985,000	$89,545	10% of direct costs	Older Adult Partnership Assessment and Care Management To provide multiple clinical and professional assessments of older adults.
DPH CMHS	Federal pass-through to State	CFDA 93.958	7/1/02-6/30/03	$75,522	$7,552	10 % of direct cost	Youth Development and Crime Prevention I Services for youth recently released from or at risk of entering into the juvenile probation system.
DPH CMHS	Federal pass-through to State	CFDA 93.958	7/1/02-6/30/03	$685,821	-$0-	N/A	Dual Diagnosis (SAMHSA) Dual diagnosis training and specialists to increase treatment capacity for dually disorded clients in City mental health clinics.

CITY COUNTY OF SAN FRANCISCO
DEPARTMENT OF PUBLIC HEALTH
RECURRING FY 2002-2003 STATE GRANTS, SCHEDULE A

Program/ Sub-Program	Agency	State Contract. #	FY-02-03 Grant Term	FY-02-03 Grant Amt.	FY-02-03 Indirect Costs	Indirect Cost Information	Title, Services, FY 2002-03
PHP CSAS	State	00-00246	6/28/02-6/30/03	$154,402	-$0-	N/A	Youth Development and Crime Prevention Initiative Model of coordinated and comprehensive services for youth at high risk of committing juvenile crime.
DPH CMHS	Federal pass-through to State	CFDA 93.958	7/1/02-6/30/03	$1,998,362	-$0-	N/A	SAMHSA System of Care Integrated mental health services to adults with serious mental illness and children with a serious emotional disturbance.
PHP. CHS	State	Mayor's Office	7/1/02-6/30/03	$2,613,075	-$0-	N/A	Juvenile Crime Enforcement & Account Challenge II Develop and implement strategies that provide an effective continuum of responses for the prevention, intervention, supervision, treatment, and incarceration of juvenile offenders.
DPH CMHS	State	Mayor's Office	7/1/02-6/30/03	$145,116	-$0-	N/A	SCHIFF-CARDENAS AB1913 Juvenile Allocation CMHS-Child, Youth & Families Repeated Offender Prevention Project (ROPP) Schiff-Cardenas AB 1913 Grant Juvenile Allocation from Mayor's Criminal Justice Council (MCJC)
TOTALS:				$28,302,028	$746,328		

2. Review by Mental Health Board

Under separate cover

3. Signed Assurance of Compliance

ASSURANCE OF COMPLIANCE WITH TITLE XIX OF THE PUBLIC HEALTH SERVICE ACT
REQUIREMENTS ON USE OF ALLOTMENTS
As amended by Public Law (P.L) 102-321 and P.L. 106-310

The county, as recipient of grant funds, acknowledges and agrees to the following:

Section 1911(b) PURPOSE OF GRANTS

(b) Purpose of Grants - A funding agreement for a grant under subsection (a) is that, subject to Section 1916, the State involved will expend the grant only for the purpose of--

(b)(1) carrying out the plan submitted under Section 1912(a) by the state for the fiscal year involved;

(b)(2) evaluating programs and services carried out under the plan; and

(b)(3) planning, administration, and educational activities related to providing services under the plan.

Section 1912 STATE PLAN FOR COMPREHENSIVE COMMUNITY MENTAL HEALTH SERVICES FOR CERTAIN INDIVIDUALS

(a) In General - The Secretary may make a grant under Section 1911 only if--

(a)(1) the state involved submits to the Secretary a plan for providing comprehensive community mental health services to adults with a serious mental illness and to children with a serious emotional disturbance;

(a)(2) the plan meets the criteria specified in subsection (b); and

(a)(3) the plan is approved by the Secretary.

Section 1913(c) CRITERIA FOR MENTAL HEALTH CENTERS

(c) Criteria for Mental Health Centers - The criteria referred to in subsection (b)(2) regarding community mental health centers are as follows--

(c)(1) With respect to mental health services, the centers provide services as follows;

(c)(1)(A) Services principally to individuals residing in a defined geographic area (hereafter in the subsection referred to as a "service area");

(c)(1)(B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility;

(c)(1)(C) 24-hour-a-day emergency care services;

(c)(1)(D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services;

(c)(1)(E) Screening for patients being considered for admission to state mental health facilities to determine the appropriateness of such admission;

(c)(2) The mental health services of the centers are provided, within the limits of the capacities of the centers, to any individual residing or employed within the service area of the center regardless of ability to pay for such services;

(c)(3) The mental health services of the centers are available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care;

Section 1916 RESTRICTIONS ON USE OF PAYMENTS

(a) In General - A funding agreement for a grant under Section 1911 is that the state involved will not expend the grant--

(a)(1) to provide inpatient services;

(a)(2) to make cash payments to intended recipients of health services;

(a)(3) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;

(a)(4) to satisfy any requirement for the expenditure of non-federal funds as a condition for the receipt of federal funds; or

(a)(5) to provide financial assistance to any entity other than a public or nonprofit private entity.

(b) Limitation on Administrative Expenses - A funding agreement for a grant under Section 1911 is that the state involved will not expend more than five percent of the grant for administrative expenses with respect to the grant.

Counties have a ten percent administrative cap (see MH 1779)

Section 1946 PROHIBITIONS REGARDING RECEIPT OF FUNDS

(a) Establishment -

(a)(1) Certain false statements and representation - A person shall not knowingly and willfully make or cause to be made any false statement or representation of a material fact in connection with the furnishing of items or services for which payments may be made by a state from a grant made to the state under Section 1911 or 1921.

(a)(2) Concealing or failing to disclose certain events - A person with knowledge of the occurrence of any event affecting the initial or continued right of the person to receive any payments from a grant made to a state under Section 1911 or 1921 shall not conceal or fail to disclose any such event with an intent fraudulently to secure such payment either in a greater amount than is due or when no such amount is due.

(b) Criminal Penalty for Violation of Prohibition - Any person who violates any prohibition established in subsection 9a) shall for each violation be fined in accordance with Title 18, United States Code, or imprisoned for not more than five years, or both.

Section 1947 NONDISCRIMINATION

(a) In General -

(a)(1) Rule of construction regarding certain civil rights laws - For the purpose of applying the prohibitions against discrimination on the basis of age under the Age Discrimination Act of 1975, on the basis of handicap under Section 504 of the Rehabilitation Act of 1973, on the basis of sex under Title IX of the Education Amendments of 1972, or on the basis of race, color, or national origin under Title VI of the Civil Rights Act of 1964, programs and activities funded in whole or in part with funds made available under Section 1911 or 1921 shall be considered to be programs and activities receiving federal financial assistance.

(a)(2) Prohibition - No person shall on the grounds of sex (including, in the case of a woman, on the grounds that the woman is pregnant), or on the grounds of religion, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any program or activity funded in whole or in part with funds made available under Section 1911 or 1921.

(b) Enforcement -

(b)(1) Referrals to Attorney General after notice: Whenever the Secretary finds that a state, or an entity that has received a payment pursuant to Section 1911 or 1921, has failed to comply with a provision of law referred to in subsection (a)(1), with subsection (a)(2), or with and applicable regulation (including one prescribed to carry out subsection (a)(2), the Secretary shall notify the Chief Executive Officer of the state and shall request the Chief Executive Officer to secure compliance. If within a reasonable period of time, not to exceed 60 days, the Chief Executive Officer fails or refuses to secure compliance, the Secretary may--

(b)(1)(A) refer the matter to the Attorney General with a recommendation that an appropriate civil action be instituted;

(b)(1)(B) exercise the powers and functions provided by the Age Discrimination Act of 1975, Section 504 of the Rehabilitation Act of 1973, Title IX of the Education Amendment of 1972, or Title VI of the Civil Rights Act of 1964, as may be applicable; or

(b)(1)(C) take such other actions as may be authorized by law.

(b)(2) Authority of Attorney General - When a matter is referred to the Attorney General pursuant to paragraph (b)(1)(A), or whenever the Attorney General has reason to believe that a state or an entity is engaged in a pattern or practice in violation of a provision of law referred to in subsection (a)(1) or in violation of subsection (a)(2), the Attorney General may bring a civil action in any appropriate district court of the United States for such relief as may be appropriate, including injunctive relief.

Linda Wang
Signature of Official Authorized
to Sign Application

August 29, 2002
Date

4. Signed Certifications

ENCLOSURE I

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (SAMHSA) BLOCK GRANT SFY 2002-03 PLANNING ESTIMATE

COUNTY: SAN FRANCISCO ISSUE DATE: April 25, 2002

PROPOSED ALLOCATION $ 3,685,737

Base Allocation	$1,939,394
Dual Diagnosis Set-Aside	$ 685,821
Youth Development & Crime Prevention	$ 75,522
Older Adult System of Care	$ 985,000

The County Department of Mental Health requests continuation of the Substance Abuse and Mental Health Services Administration (SAMHSA), Community Mental Health Services Block Grant. These funds will be used in accordance with 42 U.S.C.A., Sections 300x through 300x-13, as it read on January 1, 1992, and amended by Public Law (PL) 102-321, and will be used as stated in the enclosed Assurance of Compliance with Federal Requirements on Use of Allotments, and the Certification Statements.

The amount is the proposed total expenditure level for SFY 2002-03. The amount identified above is subject to change based on the level of appropriation approved in the State Budget Act of 2002. In addition, this amount is subject to adjustments for a net reimbursable amount to the county. The adjustments include, but are not limited to, Gramm-Rudmann-Hollings (Federal Deficit Reduction Act) reductions, prior year audit recoveries, federal legislative mandates applicable to categorical funding, augmentations, etc. The net amount reimbursable will be reflected in future allocations and/or advance payments as the specific dollar amounts of adjustments become known for each county.

The county should use this amount for planning purposes and to build the county's SFY 2002-03 base budget for SAMHSA Block Grant funded mental health programs.

Linda Wang, LCSW, Acting
County Mental Health Director

August 29, 2002
Date

CERTIFICATIONS

CERTIFICATION REGARDING LOBBYING

1) No federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person influencing or attempting to influence an officer or employee of any agency, a Member of Congress, and officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

2) If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 for each such failure.

SALARY CAP

The undersigned certifies that no grant funds will be used to pay an individual salary at a rate in excess of $166,700 per year, not including benefits.

DRUG FREE WORK ENVIRONMENT

The undersigned certifies that reasonable efforts are made to maintain a drug-free work place in all programs supported by the Block Grant funds.

CERTIFICATION REGARDING DEBARMENT, SUSPENSION INELIGIBILITY AND VOLUNTARY EXCLUSION - LOWER TIER COVERED TRANSACTIONS

1) The prospective lower tier participant certified, by submission of this proposal, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency.

2) Where the prospective lower tier participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal/application.

Linda Wang
Signature of Official Authorized
to Sign Application

August 29, 2002
Date

Attachment 3

CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State of local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable Federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing this certification, the offeror/contractor (for acquisitions) or applicant/grantee (for grants) certifies that the submitting organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The submitting organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

Linda Wang
Signature of Official Authorized
to Sign Application

August 29, 2002
Date

5. Completed Program Data Sheet

Program Data Sheet Attachment 4

2002-2003 SAMHSA MENTAL HEALTH BLOCK GRANT PROGRAM DATA SHEET

Complete one sheet for each SAMHSA funded program (as budgeted).

COUNTY: San Francisco

PROGRAM TITLE: Adult Systems of Care/Base Allocation

PROGRAM CONTACT/TITLE: Linda Wang

Phone #: 255-3421 FAX: 255-3567

E-Mail:

SAMHSA FUNDING LEVEL: (MH 1779, Line 38, Net Cost) $ 1,878,049.

TARGET POPULATION(S): (ESTIMATED NUMBER OF CONSUMERS TO BE SERVED IN THE YEAR WITH SAMHSA FUNDS)

SMI ADULT 500 # SMI OLDER ADULT 50 # SED CHILD

TYPES OF SERVICE(S) PROVIDED: (CHECK ALL THAT ARE APPLICABLE)

ASSESSMENT	X	CASE MANAGEMENT	X
COLLATERAL SERVICES		CRISIS INTERVENTION	
CRISIS STABILIZATION		DAY CARE REHABILITATIVE	
GROUP THERAPY		INDIVIDUAL THERAPY	
IN-HOME SERVICES		INTENSIVE DAY TREATMENT	
MEDICATION SUPPORT		OUTREACH	X
PEER COUNSELING	X	SOCIALIZATION	
SUBSTANCE ABUSE COUNSELING		VOCATIONAL	
OTHER:			

Please complete the following table if in the above program you have discrete sub-programs serving any of the specific sub-populations listed below or a consumer operated program:

	DUAL DIAGNOSIS	HOMELESS	FORENSIC	MINORITIES	CONSUMER OPERATED	TRANSITIONAL AGE YOUTH
ESTIMATED NUMBER OF SMI ADULT						
FUNDING LEVEL	$	$	$	$	$	$
ESTIMATED NUMBER OF SMI OLDER ADULT						
FUNDING LEVEL	$	$	$	$	$	$
ESTIMATED NUMBER OF SED CHILDREN						
FUNDING LEVEL	$	$	$	$	$	$

ADDITIONAL COMMENTS:

Program Data Sheet Attachment 4

2002-2003 SAMHSA MENTAL HEALTH BLOCK GRANT
PROGRAM DATA SHEET

Complete one sheet for each SAMHSA funded program (as budgeted).

OUNTY: San Francisco

ROGRAM TITLE: Older Adult Services

ROGRAM CONTACT/TITLE: Tom Mesa

Phone #: 255-3749 FAX: 255-3567

E-Mail: ____________________

AMHSA FUNDING LEVEL: (MH 1779, Line 38, Net Cost) $ 975,000

ARGET POPULATION(S): (ESTIMATED NUMBER OF CONSUMERS TO BE SERVED IN THE YEAR WITH SAMHSA FUNDS)

SMI ADULT 50 # SMI OLDER ADULT ______ # SED CHILD ______

YPES OF SERVICE(S) PROVIDED: (CHECK ALL THAT ARE APPLICABLE)

SESSMENT	X	CASE MANAGEMENT	X
LLATERAL SERVICES	X	CRISIS INTERVENTION	X
RISIS STABILIZATION	X	DAY CARE REHABILITATIVE	
ROUP THERAPY		INDIVIDUAL THERAPY	X
-HOME SERVICES	X	INTENSIVE DAY TREATMENT	
EDICATION SUPPORT		OUTREACH	X
EER COUNSELING	X	SOCIALIZATION	X
UBSTANCE ABUSE COUNSELING		VOCATIONAL	
THER: ____________			

Please complete the following table if in the above program you have discrete sub-programs serving any of the specific sub-populations listed below or a consumer operated program:

	DUAL DIAGNOSIS	HOMELESS	FORENSIC	MINORITIES	CONSUMER OPERATED	TRANSITIONAL AGE YOUTH
STIMATED NUMBER OF MI ADULT						
UNDING LEVEL	$	$	$	$	$	$
STIMATED NUMBER OF MI OLDER ADULT						
UNDING LEVEL	$	$	$	$	$	$
STIMATED NUMBER OF ED CHILDREN						
UNDING LEVEL	$	$	$	$	$	$

DDITIONAL COMMENTS:

Program Data Sheet Attachment 4

2002-2003 SAMHSA MENTAL HEALTH BLOCK GRANT PROGRAM DATA SHEET

Complete one sheet for each SAMHSA funded program (as budgeted).

COUNTY: Youth Development and Crime Prevention

PROGRAM TITLE: Sai-Ling Chan-Sew

PROGRAM CONTACT/TITLE: ____

Phone #: 255-3439 FAX: 255-3567

E-Mail: ____

SAMHSA FUNDING LEVEL: (MH 1779, Line 38, Net Cost) $ 118,089

TARGET POPULATION(S): (ESTIMATED NUMBER OF CONSUMERS TO BE SERVED IN THE YEAR WITH SAMHSA FUNDS)

SMI ADULT ____ # SMI OLDER ADULT ____ # SED CHILD X 70

TYPES OF SERVICE(S) PROVIDED: (CHECK ALL THAT ARE APPLICABLE)

ASSESSMENT	X	CASE MANAGEMENT	X
COLLATERAL SERVICES	X	CRISIS INTERVENTION	X
CRISIS STABILIZATION		DAY CARE REHABILITATIVE	
GROUP THERAPY	X	INDIVIDUAL THERAPY	X
IN-HOME SERVICES		INTENSIVE DAY TREATMENT	
MEDICATION SUPPORT		OUTREACH	X
PEER COUNSELING	X	SOCIALIZATION	X
SUBSTANCE ABUSE COUNSELING	X	VOCATIONAL	X
OTHER: ____			

Please complete the following table if in the above program you have discrete sub-programs serving any of the specific sub-populations listed below or a consumer operated program:

	DUAL DIAGNOSIS	HOMELESS	FORENSIC	MINORITIES	CONSUMER OPERATED	TRANSITIONAL AGE YOUTH
ESTIMATED NUMBER OF SMI ADULT						
FUNDING LEVEL	$	$	$	$	$	$
ESTIMATED NUMBER OF SMI OLDER ADULT						
FUNDING LEVEL	$	$	$	$	$	$
ESTIMATED NUMBER OF SED CHILDREN						
FUNDING LEVEL	$	$	$	$	$	$

ADDITIONAL COMMENTS:

2002-2003 SAMHSA MENTAL HEALTH BLOCK GRANT PROGRAM DATA SHEET

Complete one sheet for each SAMHSA funded program (as budgeted).

COUNTY: San Francisco

PROGRAM TITLE: Dual Diagnosis set aside

PROGRAM CONTACT/TITLE: Josephine McCreary

Phone #: 255-3723 FAX: 255-3567

E-Mail: ____________

SAMHSA FUNDING LEVEL: (MH 1779, Line 38, Net Cost) $1,139,288

TARGET POPULATION(S): (ESTIMATED NUMBER OF CONSUMERS TO BE SERVED IN THE YEAR WITH SAMHSA FUNDS)

# SMI ADULT 150 # SMI OLDER ADULT ______ # SED CHILD ______

TYPES OF SERVICE(S) PROVIDED: (CHECK ALL THAT ARE APPLICABLE)

ASSESSMENT	X	CASE MANAGEMENT	X
COLLATERAL SERVICES		CRISIS INTERVENTION	X
CRISIS STABILIZATION		DAY CARE REHABILITATIVE	
GROUP THERAPY	X	INDIVIDUAL THERAPY	X
N-HOME SERVICES		INTENSIVE DAY TREATMENT	
MEDICATION SUPPORT	X	OUTREACH	X
PEER COUNSELING	X	SOCIALIZATION	
SUBSTANCE ABUSE COUNSELING		VOCATIONAL	
OTHER: ______			

Please complete the following table if in the above program you have discrete sub-programs serving any of the specific sub-populations listed below or a consumer operated program:

	DUAL DIAGNOSIS	HOMELESS	FORENSIC	MINORITIES	CONSUMER OPERATED	TRANSITIONAL AGE YOUTH
ESTIMATED NUMBER OF SMI ADULT						
FUNDING LEVEL	$	$	$	$	$	$
ESTIMATED NUMBER OF SMI OLDER ADULT						
FUNDING LEVEL	$	$	$	$	$	$
ESTIMATED NUMBER OF SED CHILDREN						
FUNDING LEVEL	$	$	$	$	$	$

ADDITIONAL COMMENTS:

2002-2003 SAMHSA MENTAL HEALTH BLOCK GRANT
PROGRAM DATA SHEET

Complete one sheet for each SAMHSA funded program (as budgeted).

COUNTY: San Francisco

PROGRAM TITLE: Family Mosaic/Base Allocation

PROGRAM CONTACT/TITLE: Sai-ling Chan-Sew

Phone #: 255-3439 FAX: 255-3567

E-Mail: ____________

SAMHSA FUNDING LEVEL: (MH 1779, Line 38, Net Cost) $ 562,814

TARGET POPULATION(S): (ESTIMATED NUMBER OF CONSUMERS TO BE SERVED IN THE YEAR WITH SAMHSA FUNDS)

SMI ADULT ______ # SMI OLDER ADULT ______ # SED CHILD x200

TYPES OF SERVICE(S) PROVIDED: (CHECK ALL THAT ARE APPLICABLE)

ASSESSMENT	____	CASE MANAGEMENT	____
COLLATERAL SERVICES	____	CRISIS INTERVENTION	____
CRISIS STABILIZATION	____	DAY CARE REHABILITATIVE	____
GROUP THERAPY	____	INDIVIDUAL THERAPY	____
IN-HOME SERVICES	____	INTENSIVE DAY TREATMENT	____
MEDICATION SUPPORT	____	OUTREACH	____
PEER COUNSELING	____	SOCIALIZATION	____
SUBSTANCE ABUSE COUNSELING	____	VOCATIONAL	____
OTHER: Support Services	X		

Please complete the following table if in the above program you have discrete sub-programs serving any of the specific sub-populations listed below or a consumer operated program:

	DUAL DIAGNOSIS	HOMELESS	FORENSIC	MINORITIES	CONSUMER OPERATED	TRANSITIONAL AGE YOUTH
ESTIMATED NUMBER OF SMI ADULT						
FUNDING LEVEL	$	$	$	$	$	$
ESTIMATED NUMBER OF SMI OLDER ADULT						
FUNDING LEVEL	$	$	$	$	$	$
ESTIMATED NUMBER OF SED CHILDREN						
FUNDING LEVEL	$	$	$	$	$	$

ADDITIONAL COMMENTS:

6. Federal Grant Detailed Provider Budget

SAMHSA BLOCK GRANT

State of California
Department of Mental Health

Health & Human Services Agency

Federal Grant Detailed Program Budget
MH 1779 REV(3/99)

SUBMISSION DATE 27-Aug-02

COUNTY: San Francisco

CONTACT PERSON: Tina Tong Yee, PhD

PROGRAM NAME: Adult System of Care

FISCAL YEAR: FY 02-03

TELEPHONE NO.: (415)255-3422

PROVIDER NUMBER(S): N/A

	STAFFING			1	2	3
	TITLE OF POSITION		FTE	Last Approved	Request or Change	Total
1	1424 Clerk Typist		3.0	104,080	8,102	112,182
2	1426 Sr. Clerk Typist		1.0	45,890	(2,001)	43,889
3	1654 Principal Accountant		0.5	34,216	1,437	35,653
4	1820 Jr. Adm. Analyst		1.0	49,504	(2,863)	46,641
5	1822 Consumer Analyst		2.0	130,104	(1,566)	128,538
6	2320 Registered Nurse		2.5	173,030	12,057	185,087
7	2822 Mental Health Educator		1.0	67,652	2,762	70,414
8	2910 Social Worker		3.0	154,440	(5,367)	149,073
9	2930 Psych Social Worker		5.0	324,485	25,646	350,131
10	2932 Sr. Psych Social Worker		1.0	72,436	2,784	75,220
11						
12	Premium Pay 4%(24 hr. Mobile Crisis Coverage)			-	47,870	47,870
13	Salaries sub-total		20.00	1,155,837	88,861	1,244,698
14	Mandatory Fringes 25%			300,519	10,634	311,153
15						
16	Total Staff Expenses(sum lines 1-15)			1,456,356	99,495	1,555,851
17						
18	Medical Services Contracts			176,606	110,586	287,192
19	Instituto Familiar (Adult SSOC)	26,086				
20	Westbay Pilipino Multi Service	60,000				
21	Westside CMHC (Client Flex Funding)	77,000				
22	Westside CMHC (Consultation)	47,300				
23	SF Mental Health Board	26,152				
24	SF Study Center (Peer Stipend Prog.)	50,654				
25						
26	Equipment					
27	Vehicle Purchase (ordered FY02,delivery Jan. '03)			50,000	(23,526)	26,474
28						
29	Computers:					
30	Computer Server			25,000	(25,000)	-
31	Computers			237,600	(237,600)	-
32	Printers			13,800	(13,800)	-
33	Workstation/desk & printer tables			27,000	(27,000)	-
34	Datalines @ Center for Special Problem			12,000	(3,468)	8,532
35						
36	Other Expenses:					
37						
38	County Administrative Costs			-	-	-
39	NET PROGRAM EXPENSES (SUM LINES 16-38)			1,998,362	(120,313)	1,878,049
40	Other Funding Sources: Federal Funds					
41	Non-Federal Funds					
42	Total Other Funding Sources (sum lines 40 & 41)			-	-	-
43	GROSS COST OF PROGRAMS(sum lines 39 & 42)**			1,998,362	(120,313)	1,878,049

**Total Gross Cost for FY 02-03 includes ESTIMATED carry forward of unexpended funds from FY 01-02 in the amount of $ 420,336.

DMH APPROVAL TERI NEWBY
Telephone: (916) 654-3254
Date:

SAMHSA BLOCK GRANT

State of California
Department of Mental Health

Health & Human Services Agency

Federal Grant Detailed Program Budget
MH 1779 REV(3/99)

SUBMISSION DATE 28-Aug-02

COUNTY: San Francisco
CONTACT PERSON: Philip Tse
PROGRAM NAME: Family Mosaic Project

FISCAL YEAR: FY 02-03
TELEPHONE NO.: (415)255-3637
PROVIDER NUMBER(S): N/A

STAFFING TITLE OF POSITION	FTE	1 Last Approved Budget 00-01	2 Request or Change	3 Total
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
15				
17 Total Staff Expenses (sum lines 1-16)	-	-	-	-
18				
19 Equipment				
20 Copier		6,000	-	6,000
21				
22				
23 Supplies				
24 Postage & other supplies		6,500	-	6,500
25				
26				
27 Travel				
28 Client Transportation		41,296	-	41,296
29				
30 Other Expenses		102,611	-	102,611
31 Rent		8,301	-	8,301
32 Telephone		500	-	500
33 Duplication & Printing		9,640	-	9,640
34 Miscellaneous ✓			-	
35 Subcontracts (see attachment)		306,833	81,133	387,966
36				
37				
38 County Administrative Costs		-	-	-
39 NET PROGRAM EXPENSES (SUM LINES 17-38)		481,681	81,133	562,814
40 Other Funding Sources: Federal Funds				
41 Non-Federal Funds				
42 Total Other Funding Sources(sum lines40-41)		-	-	-
43 GROSS COST OF PROGRAMS(sum lines 39and 42)**		481,681	81,133	562,814

DMH APPROVAL TERI NEWBY
Telephone: (916) 654-3254
Date:

**Total Gross Cost for FY 02-03 includes ESTIMATED carry forward of unexpended funds from FY 01-02 in the amount of S 81,133.

SAMHSA BUDGET
Family Mosaic Budget Detail
FY 02-03 (July 1, 2002-June 30, 2003)

DESCRIPTION	TOTAL
EQUIPMENT	
Copier	6,000
SUPPLIES	
Postage & supplies	6,500
TRAVEL	
Client transportation	41,296
OTHER EXPENSES	
Rent	102,611
Telephone	8,301
Duplication & Printing	500
Msc.	9,640

SUBCONTRACTS:

	Title	FTEs	Names	Subtotal	TOTAL
IFR	Operation Clerk	1.00	Yule Dorn	30,763	
	Contract Outreach Specialist	1.00	vacant	36,792	
	Contract Outreach Specialist	0.50	Jenny Gong	17,510	
	Salary:			85,065	
	Fringe Benefits:			20,416	
	Salary & fringe:			105,481	
	Materials and Supplies		carry forward from 01-02	10,000	
	Consulting		carry forward from 01-02	63,093	
	subtotal:			178,574	
	Indirect cost:		($8,040 carry forward from 01-0	19,642	
	IFR total:	2.50		198,216	
BVHP	Sr. Accountant	1.00	Connie Relojo	44,039	
	Research Data Manager	0.50	Genevieve Guertin	17,372	
	Foster Care Planner	0.50	Rebecca Anaya	23,841	
	Data Entry Clerk	0.25	Jesiree Bravo	5,550	
	Administrative Aid	0.20	Fernandez	7,130	
	Salary:			97,932	
	Fringe Benefits			23,502	
	Salary & fringe:			121,434	
	Consulting			49,783	
	Student Stipends			2,086	
	subtotal:			173,303	
	Indirect cost:			16,447	
	BVHP total:	2.45		189,750	
TOTAL SUBCONTRACTS:					387,966

TOTAL SAMHSA BUDGET DETAIL AT FMP			562,814
Subcontractors:			
BVHP	189,750		
IFR	198,216	($81,133 carry forward from 01-02)	
	387,966		

8/27/02

SAMHSA BLOCK GRANT

State of California
Department of Mental Health

Health & Human Services Agency

Federal Grant Detailed Program Budget
MH 1779 REV(3/99)

SUBMISSION DATE 28-Aug-02

COUNTY: San Francisco

CONTACT PERSON: Tina Tong Yee, PhD

PROGRAM NAME: Adult System of Care and Family Mosaic Project

FISCAL YEAR: FY 02-03

TELEPHONE NO.:

PROVIDER NUMBER(S): N/A

	STAFFING			1	2	3
	TITLE OF POSITION		FTE	Approved Budget 00-01	Request or Change	Total
1						
2						
3	SEE ATTACHED					
4						
5						
6	Total Staff Expenses (sum lines 1-5)		20.00	1,456,356	99,495	1,555,851
7						
8						
9	Consultant Costs: Medical Service Contracts			176,606	110,586	287,192
10	Instituto Familiar (Adult SSOC)	26,086				
11	Westbay Pilipino Multi Service	60,000				
12	Westside CMHC (Client Flex Funding)	77,000				
13	Westside CMHC (Consultation)	47,300				
14	SF Mental Health Board	26,152				
15	SF Study Center (Peer Stipend Prog.)	50,654				
16						
17						
18						
19						
20						
21						
22	Equipment (Where feasible lease or rent) (itemize)					
23	Vehicle Purchase (ordered FY02,delivery Jan. '03)			50,000	(23,526)	26,474
24	Wheelchairs			-	-	
25						
26	Computers & Software, incl. Datalines			315,400	(306,868)	8,532
27						
28						
29	Travel, Per diem, Mileage & Vehicle Rental Lease					
30						
31	Other Expenses					
32						
33						
34	Family Mosaic (see attached)			481,681	81,133	562,814
35						
36						
37						
38	County Administrative Costs			-	-	-
39	NET PROGRAM EXPENSES (SUM LINES 6-38)			2,480,043	(39,180)	2,440,863
40	Other Funding Sources: Federal Funds					
41	Non-Federal Funds					
42	Total Other Funding Sources(sum lines 40 & 41)			-	-	-
43	GROSS COST OF PROGRAMS(sum lines 39 and 42)**			2,480,043	(39,180)	2,440,863

DMH APPROVAL TERI NEWBY
Telephone: (916) 654-3254
Date:

**Total Gross Cost for FY 02-03 Includes ESTIMATED carry forward of unexpended funds from FY 01-02 In the amount of $ 501,469.

SAMHSA BLOCK GRANT

State of California
Department of Mental Health

Health & Human Services Agency

Federal Grant Detailed Program Budget
MH 1779 REV(3/99)

SUBMISSION DATE 27-Aug-02

COUNTY: San Francisco

FISCAL YEAR: Fy 02-03

CONTACT PERSON: Philip Tse

TELEPHONE NO.: (415)255-3637

PROGRAM NAME: Family Mosaic Project Unchanged

PROVIDER NUMBER(S): N/A

	STAFFING TITLE OF POSITION	FTE	1 Last Approved Budget 00-01	2 Request or Change	3 Total
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
15					
17	**Total Staff Expenses (sum lines 1-16)**	-	-	-	-
18					
19	Equipment				
20	Copier		6,000	-	6,000
21					
22					
23	Supplies				
24	Postage & other supplies		6,500	-	6,500
25					
26					
27	Travel				
28	Client Transportation		41,296	-	41,296
29					
30	Other Expenses		102,611	-	102,611
31	Rent		8,301	-	8,301
32	Telephone		500	-	500
33	Duplication & Printing		9,640	-	9,640
34	Miscellaneous			-	
35	Subcontracts (see attachment)		306,833	81,133	387,966
36					
37					
38	County Administrative Costs				
39	NET PROGRAM EXPENSES (SUM LINES 17-38)		481,681		562,814
40	Other Funding Sources: Federal Funds				
41	Non-Federal Funds				
42	Total Other Funding Sources(sum lines40-41)				
43	GROSS COST OF PROGRAMS(sum lines 39and 42)**				

DMH APPROVAL TERI NEWBY
Telephone: (916) 654-3254
Date:

Total Gross Cost for Fy 02-03 Includes roll-over of unexpended funds for Fy 01-02
In the amount of $81,133

SAMHSA BUDGET
Family Mosaic Budget Detail
FY 02-03 (July 1, 2002-June 30, 2003)

DESCRIPTION					TOTAL
EQUIPMENT					
Copier					6,000
SUPPLIES					
Postage & supplies					6,500
TRAVEL					
Client transportation					41,296
OTHER EXPENSES					
Rent					102,611
Telephone					8,301
Duplication & Printing					500
Msc.					9,640
SUBCONTRACTS:					
	Title	FTEs	Names	Subtotal	
IFR	Operation Clerk	1.00	Yule Dorn	30,763	
	Contract Outreach Specialist	1.00	vacant	36,792	
	Contract Outreach Specialist	0.50	Jenny Gong	17,510	
	Salary:			85,065	
	Fringe Benefits:			20,416	
	Salary & fringe:			105,481	
	Materials and Supplies		carry forward from 01-02	10,000	
	Consulting		carry forward from 01-02	63,093	
	subtotal:			178,574	
	Indirect cost:		($8,040 carry forward from 01-0	19,642	
	IFR total:	2.50		198,216	
BVHP	Sr. Accountant	1.00	Connie Relojo	44,039	
	Research Data Manager	0.50	Genevieve Guertin	17,372	
	Foster Care Planner	0.50	Rebecca Anaya	23,841	
	Data Entry Clerk	0.25	Jesiree Bravo	5,550	
	Administrative Aid	0.20	Fernandez	7,130	
	Salary:			97,932	
	Fringe Benefits			23,502	
	Salary & fringe:			121,434	
	Consulting			49,783	
	Student Stipends			2,086	
	subtotal:			173,303	
	Indirect cost:			16,447	
	BVHP total:	2.45		189,750	
TOTAL SUBCONTRACTS:					387,966
TOTAL SAMHSA BUDGET DETAIL AT FMP					562,814

Subcontractors:

BVHP	189,750	
IFR	198,216	($81,133 carry forward from 01-02)
	387,966	

8/27/02

SAMHSA BLOCK GRANT

State of California
Department of Mental Health

Health & Human Services Agency

Federal Grant Detailed Program Budget
MH 1779 REV(3/99)

SUBMISSION DATE 27-Aug-02

COUNTY: San Francisco

FISCAL YEAR: FY 02-03

CONTACT PERSON: Josephine McCreary

TELEPHONE NO.: (415)255-3723

PROGRAM NAME: **Dual Diagnosis Set-Aside**

PROVIDER NUMBER(S): N/A

	STAFFING			1	2	3
	TITLE OF POSITION		FTE	Last Approved	Request or Change	Total
1	2232 Sr. Physician Specialist		1.0	61,788	75,246	137,034
2	2574/2932 Clinical Psychologist		1.0	37,044	31,840	68,884
3	2930/2931Psychiatric Social Worker		3.0	99,975	97,823	197,798
4						
5	Premium Pay 3.3%			-	13,334	13,334
6	**Salaries sub-total**		5.0	198,807	218,243	417,050
7	Mandatory Fringes 25%			52,014	52,249	104,263
8	**Total Staff Expenses(sum lines 1-7)**			**250,821**	**270,492**	**521,313**
9						
10	**Medical Services Contracts**			375,000	179,187	554,187
11	Richmond Area Multi-Services	75,000				
12	Asian American Recovery Services	75,000				
13	Westside CMHS - Client Flex funding	55,000				
14	Westside - Training and Consultation	192,500				
15	Baker Places - Housing	100,000				
16	SF Study Center(Consumer Stipend Pr	28,534				
17	SF Study Center (Student Stipends)	28,153				
18						
19						
20	**Materitals & Supplies**			-	63,788	63,788
21	- Including 5 workstations, misc. materials such					
22	as pagers, phones, postage, copying paper.					
23						
24	**Equipment**					
25	Vehicle Purchase			22,550	(22,550)	-
26	Wheelchairs for disabled indigent clients			37,450	(37,450)	-
27						
28						
29	County Administrative Costs			-	-	-
30	NET PROGRAM EXPENSES (SUM LINES 8-29)			685,821	-	1,139,288
31	Other Funding Sources: Federal Funds					
32	Non-Federal Funds					
33	Total Other Funding Sources(sum lines23 & 24)			-	-	-
34	GROSS COST OF PROGRAMS(sum lines 30& 33)**			685,821	-	1,139,288

**Total Gross Cost for FY 02-03 Includes ESTIMATED carry forward of unexpended funds from FY 01-02 In the amount of $ 453,467.

DMH APPROVAL TERI NEWBY
Telephone: (916) 654-3254
Date:

SAMHSA BLOCK GRANT

State of California
Department of Mental Health

Health & Human Services Agency

Federal Grant Detailed Program Budget
MH 1779 REV(3/99)

SUBMISSION DATE 27-Aug-02

COUNTY: San Francisco

FISCAL YEAR: Fy 02-03

CONTACT PERSON: Philip Tse

TELEPHONE NO.: (415)255-3637

PROGRAM NAME: **Youth Development and Crime Prevention**

PROVIDER NUMBER(S): N/A

	STAFFING		1	2	3
	TITLE OF POSITION	FTE	Last Approved Budget 01-02	Request or Change	02-03 Total
1	Health Program Coordinator III	0.76	57,190	14,699	71,889
2					
3					
4					
5					
6	**Total Staff Expenses (sum lines 1**	**0.76**	**57,190**	**14,699**	**71,889**
7					
8	Office Furniture			3,000	3,000
9					
10	Supplies				
11	Postage & other supplies		2,800		2,800
12					
13	Travel				
14	Client Transportation		1,540		1,540
15					
16	Other Expenses				
17	Duplication & Printing		1,440		1,440
18					
19	Miscellaneous				
20					
21	Subcontracts (see attachment)				
22	Training		5,000	(5,000)	-
23	Indirect cost		7,552	(7,552)	-
24					
25	Westside Mental Health Services			37,420	37,420
26					
27	County Administrative Costs				
28	NET PROGRAM EXPENSES (SUM LINES 17-:		75,522	42,567	118,089
29	Other Funding Sources: Federal Funds				
30	Non-Federal Funds				
31	Total Other Funding Sources(sum lines40-41)				
32	GROSS COST OF PROGRAMS(sum lines 39and 42)**				
33					

DMH APPROVAL TERI NEWBY
Telephone: (916) 654-3254
Date:

Total Gross Cost for Fy 02-03 includes roll-over of unexpended funds for Fy 01-02 in the amount of $42,567

Community Mental Health Services
Youth Development and Crime Prevention Initiative
FY 02-03 (July 1, 2002 - June 30, 2003)
12 months budget detail

Revenue	Mental Health	Request or Change	Total
Mental Health SAMHSA Grant	75,522	42,567	118,089
Total Revenue	**75,522**	**42,567**	**118,089**

Expenditures

1 Salaries	class	title	Step	FTE	BW rate	# of pps	Total cost
Program Director	2593	HPC III	1	0.76			57,512
Total Salaries				0.76			57,512
Fringe Benefits @25%							14,378
Salary & Fringes:							**71,889**
2 Operating Expenses							
Office Furniture							3,000
Materials & Supplies							2,800
Local Travel							1,540
Copying, Printing							1,440
Total Operating Expenses							**8,780**
3 Contractual Cost							
In Westside MH contract:							
Training							5,000
Client Expenses							19,018
Evaluation							10,000
							34,018
Indirect Cost							3,402
Total Contractual cost in Westside:							**37,420**
TOTAL PROJECT							**118,089**

Note:
Total gross cost for FY 02-03 includes roll-over of unexpended funds for FY 01-02 in the amount of $42,567.

8/29/02

SAMHSA BLOCK GRANT

FEDERAL GRANT DETAILED PROGRAM BUDGET
MH 1779 REV(3/99)

SUBMISSION DATE: ____________ 27-Aug-02

COUNTY: San Francisco

CONTACT PERSON: Thomas R. Mesa, MSW, MPH

PROGRAM NAME: Older Adult Demonstration

FISCAL YEAR: 02-03

TELEPHONE NUMBER: (415) 255-3749

PROVIDER NUMBER(S): ____________

	STAFFING		1	2	3
	TITLE OF POSITION	FTE	LAST APPROVED BUDGET (FY01-02)	REQUEST OR CHANGE	TOTAL
1		0			
2		0			
3	Licensed Social Worker/Adult Protective Services W	1	$ 67,314	$ (8,054)	$ 59,260
4		0			
5		0			
6		0			
7		0			
8		n/a			
9	Benefits @ 25%		$ 16,838	$ (2,022)	$ 14,816
10					
11					$ -
12	TOTAL STAFF EXPENSES (sum lines 1 thru 11)		$ 84,152	$ (10,076)	$ 74,076
13	Consultant Costs (Itemize):		$ -		
14	Calvin Louie, CPA - Fiscal Intermediary		$ 243,920	$ (91,998)	$ 151,922
15					$ -
16					$ -
17	Equipment (Where feasible lease or rent) (Itemize):				$ -
18					$ -
19					$ -
20					$ -
21					$ -
22					$ -
23					$ -
24					$ -
25					$ -
26					$ -
27					$ -
28					
29					$ -
30	Other Expenses (Itemize): CONTRACTS				$ -
31	Workorder for Dept. of Aging & Adult Services (City)		$ 79,500	$ 9,500	$ 89,000
32	Goldman Institue on Aging subcontract		$ 44,688	$ (44,688)	$ -
33	Family Services Agency subcontract		$ 88,099	$ 107,805	$ 195,904
34	North of Market Senior Services subcontract		$ 355,096	$ 20,366	$ 375,462
35					$ -
36					$ -
37					$ -
38					$ -
39					$ -
40	COUNTY ADMINISTRATIVE COSTS		$ 89,545	$ (909)	$ 88,636
41	NET PROGRAM EXPENSES (sum lines 12 thru 37)		$ 985,000	$ (10,000)	$ 975,000
42	OTHER FUNDING SOURCES: Federal Funds				
43	Non-Federal Funds				
44	TOTAL OTHER FUNDING SOURCES (sum lines 39 & 40)		$ -	$ -	$ -
45	GROSS COST OF PROGRAM (sum lines 38 and 41)		$ 985,000	$ (10,000)	$ 975,000

Note: Carry-forward budget for use of estimated unexpended FY 01-02 funds of $ 794,243. will be submitted at a later date by separate cover.

DMH APPROVAL BY: TERI NEWBY
TELEPHONE: (916) 654-3254
DATE:

7. Program Narrative

SAMHSA GRANT RENEWAL APPLICATION FY 02-03

7. PROGRAM NARRATIVE

a. Statement of Purpose

Community Mental Health Services (CMHS) of San Francisco's Department of Public Health submits this renewal application to the Substance Abuse and Mental Health Services Administration (SAMHSA) for Fiscal Year 02-03 in the amount of $1,939,394, in addition to dual diagnosis funds of $685,821 and carry forward funds from FY 01-02 of $954,591 for a total of $3,579,806.

CMHS operates the San Francisco Mental Health Plan in order to provide eligible residents of San Francisco with access to a high quality, effective, cost-efficient system of mental health care that is community based, culturally competent, and consumer-guided. The San Francisco Mental Health Plan's goal is to promote recovery, positive functional outcomes, and reduction in the symptoms of mental illness for consumers. This includes reduction of substance abuse as well, recognizing that significant numbers of mentally ill consumers are dually diagnosed. The Mental Health Plan's ability to work towards these goals depends on a complex set of partnerships with the many other departments and agencies that serve the same population. These include health, substance abuse, social services, courts, jails, police, schools, homeless shelters, community non-profit and other government agencies. The Plan's performance in meeting its goals is measured by statewide outcome measures of consumer progress in treatment as well as consumer satisfaction.

The SAMHSA Federal Block Grant funds support the Mental Health Plan's ability to provide timely access to appropriate care for severely mentally ill (SMI) and dually diagnosed adults and older adults and seriously emotionally disturbed (SED) children and youth. The Plan is particularly focused on expanding access to community care and diverting people from institutional care whenever possible. The SAMHSA funds also enable the Mental Health Plan to provide stipends for peer counseling interns, mental health education, and outreach to individuals, who due to stigma and or cultural and linguistic barriers do not easily access mental health care. These activities promote wellness and recovery, early identification of problems, and also encourage people to seek help when they need it.

- **Adult and Older Adult System of Care**

1) Central Access: The central team that screens and refers callers to appropriate treatment from the Mental Health Plan's access phone line.
2) Crisis Case Management: A crisis intensive case manager who is assigned to provide immediate support to individual clients discharged from institutional care or who are utilizing crisis/emergency services who have not yet linked with ongoing mental health treatment and are at-risk of re-hospitalization.
3) A Patient Flow team that provides client on-site evaluations and utilization management at acute levels of care to determine a patient's readiness for discharge and placement support at the lower levels of care.

- **Dual Diagnosis enhancement**

1) Dual Disorder Training Program: An intensive dual disorder training program that incorporates principles of harm reduction, wellness and recovery, and relapse prevention with some additional focus on working with youth and dual disordered individuals with personality disorders.
2)Dual Disorder Treatment Capacity: A Dual Disorder Treatment Team that provides assessment and treatment and on-site, system-wide consultation and training. Expanded treatment capacity for dually disordered clients is provided at contracted mental health clinics and city operated clinics.

- Children's System of Care support focused on Filipino families children and youth and sexually abused youth.
- Consumer participation and community outreach through mental health education and consumer advocacy and assistance and workforce development of consumers as peer counselors and clinicians to serve cultural and limited English proficiency (LEP) populations across the System of Care.
- Family Mosaic Project wrap-around services for seriously emotionally disturbed children and adolescents.

b) Measurable Outcome Objectives for FY 02-03

1) Access: In order to improve access to mental health services, the Access Team proposes to reduce the abandoned call rate, from 9% to 7% by June 30, 2003. This will be measured using the BCMHS View software that tracks incoming phone calls from clients.

2) Crisis Case Management: The Discharge Liaison Team will assign a crisis case manager to clients discharged from the hospital who need crisis intensive case management and are not connected to the adult community system of care. Objective: The Crisis Intensive Case Manager will link a minimum of 30 clients by June 30, 2003. This will be measured using data from the Mental Health information system.

3) Patient Flow (PF): A PF Team will provide on-site evaluations and utilization management at the acute level and facilitate placement and discharge. Objective: At least 90% of patients admitted to acute inpatient will be assessed to determine readiness for discharge to appropriate level of care and assisted with community placement linkage as measured by the MHP's authorization racking system.

4) Patient Flow (PF): Continuous placement support at non-acute settings is critical to the prevention of relapse and recidivism to acute settings. Objective: To establish and implement a process for assessing patients placed in residential treatment, adult diversion units and transitional houses and facilitating their discharge and placement to lower levels of care, including permanent housing and residential care settings by June 30, 2003.

5) Augmentation of Children's System of Care: The West Bay Filipino Multi-Service Center will perform outreach, intake and case management services to at least 60 unduplicated clients and link them to appropriate services by June 30, 2003. This will be measured by the provider's reports back to the mental health program monitor based on the provider's own tracking.

6) Cultural Competence and Consumer Relations: By June 30, 2003, the mental health educator will coordinate 2 depression and suicide prevention education outreach and screenings targeting at risk populations at primary care sites and community health events, 3 cultural competency trainings for 500 participants and 24 hours of continuing education units tailored for residential care operators serving our severely mentally ill adult and older adult clients. This will be measured by training attendance rosters attendance rosters and activity logs.

7) Cultural Competence and Consumer Relations: By June 30, 2003, the analyst will have collected and analyzed system-wide staff information data that allows the MHP to assess and access culturally and linguistically competent services across our system of care. This will be measured by the inclusion of this analysis in our County Cultural Competence Plan.

Dual Disorder Enhancement FY 02-03 objectives:

8) To increase the skills of mental health clinicians serving SMI dual disordered clients in our mental health clinics by ensuring that at least 50 clinicians representing 6 programs/units are trained by June 30, 2003. Participating clinicians will be required to complete a skills based training curriculum on dual disorders.

9) To increase the number of dually disordered clients served in community mental health contracted programs by 80 by June 30, 2003. The Programs shall maintain a tracking record of clients served.

10) To increase treatment service capacity, the team of dual disorder specialists will provide assessments and treatment services for at least 100 clients with dual disorders and staff consultation and/or training at 8 program/unit sites. The Team shall maintain a record of its activities.

Family Mosaic related FY 02-03 objectives:

11) The objective is to develop a community-based Children's System of Care Planning Council that addresses the needs of all intensive care management programs and their clients in San Francisco. This objective will be measured utilizing attendance rosters for each meeting format.

12) The objective is to decrease psychiatric inpatient admission and hospital days of children and youth enrolled in Family Mosaic with a history of prior hospitalizations by at least 50% by June 30, 2003. This will be measured using the Mental Health information system hospital utilization data.

13) The objective is to decrease arrest rates of Family Mosaic enrolled children and youth by at least 50% by June 30, 2003, compared to their pre-enrollment involvement. This will be measured utilizing annual program evaluation data and outcomes reporting.

Status of FY 01-02 Objectives

1) The Access Team had an objective to reduce the abandoned call rate from 9% to 7% by June 30, 2002 based on full staffing. Due to staffing losses of nearly one third during the course of the year, abandoned rates were maintained at 9%. However, full staffing beginning May 2002 resulted in 4.6 % rate in the month of July.

2) The Access Team eligibility workers linked 424 clients to Medi-Cal entitlements which exceeded their objective of 300 clients by June 30, 2002 as measured by data tracked in their database.

3) Crisis Case Management: The Discharge Liaison Team (formerly the 24 Hour Authorization Team) met their objective to link a minimum of 30 clients in FY 01-02 to crisis case management services. Thirty- three (33) clients were successfully linked as measured by data from the Mental Health information system.

4) Long Term Care and Inpatient Linkage: In FY 01-02 the utilization review nurse assessed 376 hospitalized clients for whom long term care had been requested. The objective was to assess 250. This led to a shorter waiting time for clients on administrative days in the hospital. In February 2002, a new patient flow model that provides on-site evaluations and utilization review at the inpatient level was instituted to increase our efficiencies for assessing and placing clients in appropriate lower levels of care. This change replaced our objective to have the inpatient utilization review nurse evaluate clients admitted to the hospital.

5) Utilization Management: The addition of the 1.5 FTE data entry clerks resulted in meeting our objective to reduce the amount of time it takes to process authorization requests to no more that 5 working days, thereby achieving greater efficiencies in the utilization management process by reducing the amount of time it takes to process authorization requests.

6) Augmentation of Children's System of Care: The West Bay Filipino Multi-Service center met its objective to outreach and provide intake to 60 unduplicated clients who were linked to appropriate services in FY 01-02.

7) Cultural Competence and Consumer Relations: In FY 01-02, the mental health educator conducted 6 depression and suicide education outreach and screenings for 200 participants, targeting older adults, mono-lingual Spanish and Cantonese populations, homeless adults and the medically indigent at public primary care sites. This was more than double the numerical objectives. Objectives to coordinate 3 cultural competency trainings for 500 participants were also met. Four trainings were conducted with continuing education units for psychologists, nurses, social workers, marriage family counselors on Mental Health and Cultural and Clinical Issues for working with African Americans, Latinos, and Arab and

Muslim populations. A fourth training was on Case Management in Residential Care. A total of 767 providers attended these trainings.

8) In FY 01-02, the analyst working for the Office of Cultural Competence and Consumer Relations coordinated with staff to develop mental health educational materials in our threshold languages (currently Spanish. Vietnamese, and Cantonese). Written protocols currently in process for policy adoption, address the use of interpreters for programs serving mentally ill clients. These protocols are in compliance with National Standards for Culturally and Linguistically Appropriate Services (CLAS) and State requirements.

Status of Dual Disorder Enhancement FY 01-02 objectives:

9) Objectives to increase the capacity of mental health and substance abuse clinics to deliver services to dually disordered individuals and to maximize reimbursement through entitlements for those services by obtaining dual State certification were dropped as we learned that certifications would have limited impact. Capacity increases, instead, would be far more impacted by improving the skill level of our clinicians, which is a primary focus and objectives for FY 02-03. However, the Asian American Recovery Services, a substance abuse agency, has been certified as of July 1, 2002 for delivering mental health services, They will participate in our 02-03 Dual Disorder SAMHSA initiative to increase services to dual disordered clients.

10) The objective is to increase the number of dually disordered clients served in community mental health programs by 60 was met. RAMS, a contracted program conducted an educational outreach effort targeting the Russian speaking community to address problems with clinical depression and alcohol abuse. This resulted in dual disorder education groups as well as individual and therapy groups that reached more than 60 Russian and non-Russian individuals and their families.

Status of Family Mosaic Program (FMP) related FY 01-02 objectives:

11) The objective was to increase parent/care giver and youth participation on the Family Mosaic Advisory Board and Support Group meetings by 25% as measured attendance roster of the meetings. In October 2001, however, the Advisory Board decided to refocus its efforts to conduct, instead, a Family and Youth Informational Sharing Day that provided workshops and discussions with clients, family members, and community participants to generate new ideas to restructure the Advisory Board and Support Groups with the goal of increasing interest and participation from the community. Following a broad outreach to its community, this event successfully occurred on May 18, 2002. Follow-up to this event is currently in process.

12) The objective was to decrease psychiatric hospitalizations of children and youth enrolled in FMP with a history of prior hospitalizations by 50% by June 30, 2002. Although the data for 01-02 are currently not available, during this period, FMP experienced an 11.6% decline in the number of unique clients hospitalized, with an accompanying 10% reduction in costs. During that same period the county hospitalized only 2 fewer clients in FY2001, a reduction of 0.6%. Similarly, the total number of acute inpatient days for FMP clients decreased by 14.5%, with an approximate 3% reduction in the number of discharges from the previous year. Most noteworthy is the average length of stay for FMP clients decreased by almost 8%, whereas non-FMP clients who were hospitalized actually experienced an increase in length of stay of approximately 2%.

13) The objective was to decrease arrest rates of FMP enrolled children and youth by 50% by June 30, 2002. compared to their pre-enrollment involvement. Although the results of this data analysis are not yet available, FMP consistently has demonstrated a reduction in criminal activity of its clients over time. The CMHS outcome study (Sherwood, Dec., 2000) of juvenile recidivism among Family Mosaic enrollees with sustained felony or misdemeanor charges in the year following discharge (N=181/28%), showed an 88% decrease in the average number of crimes per youth from pre- to post-program.

14) The objective was to achieve a 70% client satisfaction rate in FY 01-02. Utilizing the 4-point Client Satisfaction Questionnaire (CSQ 8), FMP clients rated their satisfaction with services with an average rating of 89%.

c) Program Description

Program Components

1) Access Team FY 02-03

The San Francisco Mental Health Plan has a uniform system of access to services that includes numerous walk-in sites through-out the City in addition to an Access Team that responds to a central toll-free phone line. The SAMHSA funds provide substantial support for the central Access Team Function. The Access Team responds to the central phone line requests for mental health services, across all age groups, for all members and referring agencies. They link individuals to appropriate care in both mental health clinics and the private practitioner network and have the capacity to respond to emergency and crisis calls on a 24 hour a day, seven day a week basis. The Access Team receives between 90 and 100 calls a week and provides the following services:

- Information and referral to appropriate agencies: social services, entitlements, housing, physical health, and substance abuse treatments. The Mental Health Plan tracks all initial contacts to the access system whether they are service requests or requests for information.
- Membership screening and eligibility determination including establishing residency, entitlements, and third-party payer coverage. In some instances eligibility determination may need to be completed in the face to face assessment if the person is unable or unwilling to provide the information on the phone.
- Clinical screening for medical necessity: to determine if a member requires mental health services using the State required medical necessity criteria. If the clinical screening determines that mental health services are not appropriate, a referral to other appropriate services will be made. When authorizing services for members, the Access Team takes into account not only the level of functioning and medical necessity, but also the needs of special populations. In-home assessments are available to seniors, school-based services for children, and outreach to shelters for the homeless population.
- Identification, referral and linkage to appropriate treatment based on language, cultural variables, age specialization, and geographic location, modalities of treatment and client preference.

The major goals for the Access Team continue to be reducing the rate of abandoned calls to the central phone line so that more people receive access to mental health services. The SAMHSA budget for FY 02-03 includes the following Access Team components:

- (1)-1426 Senior Clerk Typist and 1.5 1424 Clerk Typist that provide data entry and clerical support for the Access Team.
- (3)-2910 Social Workers that respond to phone inquiries and triage, refer, coordinate care, screen for eligibility, and enter client data.
- (4)-2930/31 Psychiatric Social Workers/Marriage, Family and Child Counselors to do the above and also resolve complex'clinical coordination issues and authorize treatment.
- (1)-2932 Senior Psychiatric Social Worker to provide clinical supervision and manage complex authorization requests.

2) Crisis Intensive Case Management FY 02-0

The crisis case manager (1) 2931 Marriage, Family and Child Counselor) comprising this component of the SAMHSA grant support the system of care coordination for the Mental Health Plan's most vulnerable clients—those recently discharged from inpatient care. A significant percentage (40%) of hospitalized individuals is not already enrolled in a community mental health program upon discharge though they have been referred to community treatment. The crisis case manager funded by SAMHSA is assigned by the Discharge Liaison Team to clients who might not link to ongoing community treatment without the immediate support of a crisis case manager. The crisis case manager has a caseload of no more than 8-10 clients to allow for intensive work, up to 10 hours a week of service with a single client. The crisis intensive case manager provides:

- 30-90 day intensive case management including hands-on field based support and linkage to appropriate services, i.e. emergency housing, medication management, residential placement.
- Immediate emergency resources using flexible funds to prevent client decompensation and hospitalization, i.e. housing, food.
- Eligibility screening and linkage to benefits such as SSI, Medi-Cal, General Assistance and housing resources.
- Case conferences as needed with service providers, networking with family members and significant others and the client's support system
- Assessment of needs and functioning in the client's environment, clinical evaluation.
- Development and implementation of client specific system-wide plans to encourage diversion from hospitalization.
- Linkage to services across public systems including medical, welfare and education.

The FY 02-03 SAMSHA budget incorporates $77,000 in one time funds for medical service contacts that will be carried forward from Fiscal 01-02 to be used to purchase items to resolve one time needs such as food and temporary shelter in an effort to prevent client decompensation and hospitalization (flexible funding). It also provides for $43,300 for consultation on implementing an open access system and integrating health and behavior health care for SMI and SED clients.

3) Patient Flow (PF) Team FY 02-03

Beginning February of 2002, CMHS transitioned from a Long Term Care (LTC) model to a Patient Flow (PF) model in order to provide a more "client driven" as opposed to "level of care driven" system of care. Essentially, the PF model provides for on-site utilization management by a PF team at the acute/institutional level in order to increase efficiencies in the placement of our patients into the community. The PF model encompasses a comprehensive continuum of care, including acute, crisis management, long term care, residential treatment, residential care and outpatient/case management services. The model provides for intake linkage at the acute level, placement support at the lower levels of care and focused utilization management. The SAMHSA budget incorporates funding for the following staff:

- .5 FTE 2320 Registered Nurse to provide assessments of hospitalized individuals to determine their readiness for discharge to lower levels of care.
- 1 FTE 2320 Registered Nurse to provide placement support at the lower levels of care, to provide assessments at non-acute settings, work with Residential Care operators to prevent decompensation of SMI residents and resolve placement issues, including any re-instatement and transitional issues should the patient be rehospitalized.
- 1 FTE 1820 Jr. Administrative Analyst to support the reporting, tracking, and analysis functions for CPF team.

4) Dual Disorder Enhancement FY 02-03:

The focus of the dual disorder initiative is to a) implement an intensive training initiative for mental health clinic staff including a curriculum to increase the dual disorder treatment capabilities of mental health clinics across our system of care; and, b) add specialized dual disorder treatment clinicians to increase the capacity of mental health clinics to treat dual disorder clients and provide system-wide consultation and ongoing training.

The SAMHSA budget for FY 02-03 provides for a Dual Disorder Team composed of (1) 2932/35 Senior Social Worker/MFT who shall provide coordination for the Dual Disorder Training and for other dual disorder projects within Mental Health, (1) 2232 Senior Physician and (3) 2930/31 Social Worker/Marriage, Family Therapists trained as dual disorder specialists to provide additional treatment capacity for dually disordered clients in mental health clinics. The FY 02-03 SAMHSA budget also includes contracted medical services of $150,000 to fund staff to provide additional treatment capacity for dually disordered clients in contracted mental health clinics. Carryforward requests are described in the implementation section.

5) Children's System of Care FY 02-03:

The SAMHSA budget continues to augment the clinical support for certain vulnerable populations served in the children's system of care. The SAMHSA budget for FY 02-03 continues to support two half-time registered nurses (1FTE) at the Child, Adolescent, Sexual Abuse Resource Center (CASARC) located at San Francisco General Hospital to meet the needs for assessment and treatment of sexually abused children and adolescents. This unique resource involves collaboration with the District Attorney's Office and Child Welfare. The SAMHSA budget for FY 02-03 also supports $60,000 in a medical services contract with the West Bay Filipino Multi-Service Center for outreach, mental health education, case management and linkage to mental health services for Filipino families.

6) Consumer Participation and Community Outreach FY 02-03:

The SAMHSA budget for FY 02-03 continues to support some of the activities of the Office of Cultural Competence and Consumer Relations, through which the Mental Health Plan aims to increase consumer participation and community outreach. These activities take place within the framework of the CMHS Cultural Competence Plan, an essential strategy for increasing access in a community as diverse as San Francisco. The activities of the Office of Cultural Competence and Consumer Relations also reflect the Plan's commitment to consumer guided services and the goals of wellness and recovery. An ombudsman, family liaison, and consumer specialists work in this Office to develop and implement consumer, family and community initiatives. The budget incorporates 1 Analyst and 1 Mental Health Educator. The Analyst functions under the direction of the Director of the Office of Cultural Competence and Consumer Relations and helps to implement cultural competence and consumer and community outreach initiatives. In FY 02-03 this individual will collect and analyze system-wide staff information data for assessing CMHS's capacity for serving cultural and linguistic populations. The Mental Health Educator will provide training aimed at residential care providers, coordinate cultural competency trainings and conduct suicide prevention trainings and depression outreach and screenings. Both individuals are critical to the Mental Health Plan's effort to communicate information about the Plan to consumers, families, and community members. The SAMSHA budget will provide for FY 02-03 $26,152 to fund a half time staff through the Mental Health Board to assist in providing public education for gaining access to services and ending the stigma against mental illness.

A key recommendation of our CMHS Wellness and Recovery Task Force has been to increase consumer access to peer counseling through CMHS. For FY 02-03 carryforward SAMSHA funds will support a peer internship program that prepares consumer for peer counseling positions. Medical services contract to the San Francisco Study Center for $50,654 and an additional $28,534 of dual disorder funds are set aside to provide 10-15 consumers in recovery with supervised peer counseling internship experience to become peer counselors.

7) Family Mosaic Project FY 02-03:

The Family Mosaic Project uses an interdisciplinary, interagency approach to providing intensive care management and wrap-around services for almost 200 seriously emotionally disturbed children and youth enrolled in the program. The family advocate care managers are responsible for coordinating, monitoring, and implementing individualized care plans for each enrollee. These care plans incorporate the wrap-around concept in the broad scope of services that may be provided, such as respite care, tutors, mentors, anger management, transportation, and family preservation. A Children's System of Care (CSOC) Planning Council will provide parents, youth, and providers a formal mechanism for input into policies and procedures.

The SAMSHA budget for FY 02-03 continues to augment the Family Mosaic Project to provide transportation, administrative support, community outreach, data analysis, and foster care planning support to approximately 200. These dollars are sub-contracted to fiscal intermediary agencies, Instituto Familiar de la Raza and Bayview Hunters Point Foundation and include the 4.7 positions listed on the Family Mosaic Budget detail page. The carryover of $81,133 will be used to provide a stipend for a psychiatric resident from Stanford Medical Center to work with the clinical team to provide consultation to family advocates and the family involvement team.

d) Target Population

The SAMHSA Federal Block Grant funds are used to improve the San Francisco Mental Health Plan's system of care for a diverse population of seriously emotionally disturbed children and youth and seriously mentally ill (including dually diagnosed) adults and older adults. The population includes San Francisco Medi-Cal beneficiaries as well as uninsured residents who must use safety net services. In FY '01-'02, the largest groups were White (34%), African American (23%), Latino/Hispanic (13%), Chinese (10%), Filipino (3%) Russian (3%), Vietnamese (1.5%) and Native American (1%). The Family Mosaic Program has a specific target population of children and youth between the ages of 3 and 18 with serious emotional disturbance and risk of out-of-home placement as a result.

The dual disorder component of the grant aims to improve the system of care for dually disordered individuals who comprise a large percentage of the transition age youth, adult, and older adult populations. A review of January 1, 2000, through June 30, 2001 mental health and substance abuse clients showed that 3,805 (15%) mental health clients were also receiving substance abuse services, and 3,785 (20%) substance abuse clients were also receiving mental health services. The prevalence of dual disorder is likely much higher. SAMHSA's Substance Abuse and Mental Health Statistics Sourcebook (1995) states the lifetime prevalence of substance abuse for individuals with mental illness is approximately 39%.

e) Staffing

Category	Staff Title	SAMHSA Funded	Other Funding	Total FTE
Access Team	1424 Clerk	2.0	0	2.0
Access Team	1426 Sr. Clerk	1	0	1
Access Team	2910 Social Worker	3	0	3
Access Team	2930/31 Soc. Worker/MFT	4	1	5
Access Team	2932 Sr. LCSW	1	0	1
Crisis Case Mgmt	2930/31 MFT/Psych. Soc. Worker	1	1	2
Patient-Flow	1820 Jr. Analyst	1	0	1
Patient-Flow	2320 Reg. Nurse	.5	.5	1
Patient-Flow	2320 Reg. Nurse	1	1	2
Care Coordination	1424 Clerk Typist/contract clerk	1.5	0	1.5
Care Coordination	1822 Analyst	1	0	1
Care Coordination	.1654 Accountant	.5	0	..5
Children's SOC	2320 Reg. Nurse	1	0	1
Children's SOC	Contract Case Mgmt/Outreach	1	0	1
Consumer Participation & Community Outreach	1822 Analyst	1	0	1
Consumer Participation & Community Outreach	2822 Mental Health Educator	1	0	1
Category	Staff Title	SAMSHA Funded	Other Funding	Total FTE

Consumer Participation & Community Outreach	Contract Staff	.5	.5	1
Dual Disorder	2232 Sr Physician	1	0	1
Dual Disorder	2930/32 Soc. Worker/MFT	3	0	3
Dual Disorder	2932/35 Sr. Social Worker/MFT	1	0	1
Family Mosaic	Contract Planner	.5	0	.5
Family Mosaic	Contract Clerk/Admin Aide	1.2	0	1.2
Family Mosaic	Contract Data Manager	.5	0	.5
Family Mosaic	Contract Accountant	1	0	1
Family Mosaic	Contract Outreach Specialist	1.5	0	1.5

f) Cultural Competency
Given the cultural and ethnic diversity of San Francisco, the Mental Health Plan must ensure access to services in a manner that is community based, culturally competent and consumer driven. Services must be accessible to the disabled. CMHS recognizes that cultural competency is a dynamic and developmental process that must be incorporated at all levels of the system, including policy and administration, human resource development and training, planning and delivery of services and evaluation. The Director of Cultural Competence and Consumer Relations sits on the CMHS Executive team to provide system leadership in this regard. Critical components for the development and implementation of the changing system include regular assessments of the ethnicity and language of the a Cultural Competence Plan that outlines critical standards, indicators, and specific populations served; organizational assessments of the cultural competency of providers; and measures.

The Office of Cultural Competence and Consumer Relations continues to lead specific initiatives to improve the cultural competency of the Mental Health Plan. The Office assures that Mental Health Plan materials are available in threshold languages (currently Vietnamese, Spanish, and Cantonese); assists in identifying interpreter and translation resources, and works with providers through focused training efforts to expand access to the diverse populations served. All programming and training emphasizes multicultural diversity. There is a student stipend program aimed to encourage long term diversification of the human resources pool available for clinical positions. There is an African American and Gay sensitive designated program to ensure the appropriate competencies for staff hired to work with those populations. Language waivers are in place for Spanish, Cantonese, Cambodian, Vietnamese, Italian, Russian and Tagalog, to ensure hiring of staff with linguistic competencies.

g) **Designated Peer Review Representative:** Steve Seidman, Ph.D., Access Team Director.

h) **Implementation Plan:** The SAMHSA funded program is fully implemented except for the following components.
The Dual Disorder enhancement described in the revised FY 01-02 proposal projected to begin in late January 2002 experienced delays due primarily to set backs in the recruitment and hiring of appropriate and culturally competent staff, changes in administrative oversight of the Project and unexpected systems delays in the City hiring process. The expected start-date for the training program is October 2002, continuing through June 2003. The expected start-date for the program staff will be late October. One-time items in medical services contracts from FY 01-02 that will be carried over to FY 02-03 for the same purposes include: $100,000 funding to develop 3-4 apartment cooperative housing options for dual disorder clients, $49,280 for 5 workstations and miscellaneous materials and supplies, postage, pager, phones; $192,500 for training and consultants for dual disorder youth and transitional youth, and adults with additional focus on working with personality disorders, $55,000 for client flexible funds, and $28.153 for student stipends.

Carryforward expenditures that were initiated in fiscal 01-02 and scheduled for completion in 02-03 include computer purchases for $8,532 and a van for $26,474. An amount of $184,224 from carryforwards will also be utilized to offset staffing costs in 02-03 that exceed the baseline budget.

i) **Program Evaluation Plan:** The Mental Health Plan's Quality Management section conducts an annual program review of each provider that documents its status in meeting performance objectives and other Mental Health Plan requirements. The Mental Health Plan has a Quality Management Plan that incorporates a Quality Improvement Committee structure for ongoing monitoring of the Plan's progress in meeting objectives and improving its processes and outcomes for clients. Specific quality improvement projects target priority areas. For example, the Quality Management Work Plan for FY 01-02 completed an evaluation of clients discharged from long term care. The results of these projects allowed the Mental Health Plan to target areas for improvement. Several of these relate to the SAMHSA proposal objectives, for example, on improving patient flow and access.

Dual Disorder Enhancement initiative will have an evaluation component, which will be implemented by a consultant Psychologist. The evaluation will incorporate pre and post-testing of participants of the dual disorder training. The testing will assess the extent to which participants retain knowledge related to the objectives of the training. The objectives include: establishing a comprehensive knowledge base and understanding of treatment planning for dually diagnosed individuals; increasing clinician's diagnostic and treatment skills in dual diagnostic theory and practice; and enhancing familiarity and application of the harm reduction model, motivational interviewing practices, and relapse prevention strategies.

SAN FRANCISCO MENTAL HEALTH BOARD

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UNADOPTED MINUTES
Mental Health Board
Wednesday, September 11, 2002
1380 Howard Street, Room 537
San Francisco, CA 94103
6:30 p.m.

BOARD MEMBERS PRESENT: Ted Stinson (Chair); Bridgett Brown; Augusta Del Zotto, Ph.D.; Andrea Leung, L.C.S.W., A.C.S.W.; Toye Moses, Ph.D., M.P.H.; Rick Nizzardini, L.C.S.W., J.D.; Rose Chung for Supervisor Aaron Peskin; Dorothy Shaffer, R.N., N.P., M.S.N., Kate Walker; Idell Wilson; Sandy Yuen; Dennis Yun, M.S.W..

BOARD MEMBERS ON LEAVE: Bob Douglas; Carol Knight; chance martin.

BOARD MEMBERS ABSENT: Robyn Buckins.

PRESENTERS:
Ann Stangby, RN, CEM, Emergency Response Planner, Department of Public Health

Dr. Paul Koller, Senior Psychologist, San Francisco Veteran's Administration Medical Center, Post Traumatic Stress Disorder Treatment Team and Assistant Clinical Professor, Department of Psychiatry, UCSF School of Medicine

OTHERS PRESENT: Linda Wang (Director of Adult Services, Community Mental Health Services); Saumitra SenGupta, Ph.D., (CMHS Research Psychologist); Mickey Shipley (San Francisco Network of Mental Health Clients); Jackie Egland (San Francisco Community Clinic Consortium); Emeric Kalman; Helynna Brooke (MHB Executive Director); Rich Snowdon (MHB Administrator)

1.0 CALL TO ORDER AND CONSENT CALENDAR

1.1 Call to Order and Announcements from the Chair
The meeting was called to order at 6:34 p.m. by Ted Stinson, Chair.

1.2 Consent Calendar
1.2.a **RESOLUTION (MHB-2002-25): Be it resolved that the minutes of the Mental Health Board meeting of July 10, 2002, be approved as submitted. (Passed unanimously.)**

1.2.b **RESOLUTION (MHB-2002-26): Be it resolved that the Mental Health Board grants leaves of absence for the meeting of September 11, 2002, to the following members: Bob Douglas; Carol Knight; chance martin. (Passed unanimously.)**

2.0 MOMENT OF SILENCE

A moment of silence was held in memory of the victims and in honor of the heroes of September 11, 2001.

5.0 MENTAL HEALTH BOARD COMMITTEES **(This agenda item was taken out of order.)**

5.1 Report of the Chair of the Board and Executive Committee

Mr. Stinson call for discussion, public comment, and a vote on the following items:

5.1.a RESOLUTION (MHB-2002-27) IN SUPPORT OF SUPERVISOR SOPHIE MAXWELL'S INITIATIVE TO STREAMLINE THE CITY'S CONTRACTING PROCESS

WHEREAS, many nonprofit agencies which provide services to the City and County of San Francisco have contracts with a number of different City departments at the same time, and

WHEREAS, these City departments require the same nonprofit agencies to provide the same information in very different formats, and

WHEREAS, this variety of formats does not add any specific value to the contracting process for the City, and

WHEREAS, the nonprofit agencies have to spend a significant amount of administrative time to comply with the differing formats, and

WHEREAS, the nonprofit agencies need to be spending their resources as much as possible on services rather than duplicative administrative work, and

WHEREAS, the San Francisco Human Services Network has asked for a standardization of the format for core information, and

WHEREAS, Supervisor Sophie Maxwell is working closely with the San Francisco Human Services Network to create effective strategies and solutions; now, therefore

BE IT RESOLVED, that the Mental Health Board expresses its gratitude to Supervisor Maxwell for her leadership in creating the City Contracting Task Force, for her commitment to maximizing resources spent on direct services while reducing duplicative administrative work, for boosting the morale of the nonprofit agencies which provide services to the City, and for her abiding concern for the people of San Francisco who are in need. (Passed unanimously.)

5.1.b RESOLUTION (MHB-2002-28)

Be it resolved that the Mental Health Board send a letter to Robert Cabaj, M.D., Director, Community Mental Health Services and Community Behavioral Health Services, stating that the Board has reviewed Contract 02-72041, which is the contract the San Francisco Department of Public Health has with the State Department of Mental Health for a total of $3,844,098 in funding for community mental health services. (Passed unanimously.)

5.1.c SAMHSA Grant

Mr. Shipley: Is this SAMHSA grant more or less than in the past?
Ms. Wang: It's essentially the same. We had some unspent dollars from last year which we are asking to rollover to this new year. But anytime a budget remains flat you end up with a problem because of increasing costs.

Dr. Moses: What percentage of the grant is going to service?
Ms Wang: Our general principal in using this funding is that we shy away from using it for services for this reason: With direct services we can get reimbursed for Medi-Cal. But with the federal grants you can't bill for Medi-Cal, so the positions we fund are those which are not service positions. An example is Access which provides a critical function in connecting people to service, but they don't provide the service directly, and so we can't bill for their activity.

Dr. Moses: It looks like most of the money goes to personnel. Ms. Wang: Yes. Also a couple positions are for service delivery for populations where there is no other funding source.

Dr. Moses: The MHB advocates for consumers, so I just want CMHS to know that we really mean it. What consumer positions are in the grant? Ms. Wang: In this grant application, we're proposing to fund peer stipends. Peer counselors can't bill for their services, but we think these are very important positions.

Ms. Walker: On the SAMHSA grant, the professionals can be paid from the grant. Non-professionals would receive a stipend. I want to understand who the grant can support and who it can't support. Ms. Wang: This grant is pretty broad. It doesn't have stringent requirements, so it's very possible to fund positions we think consumers would qualify for. In the civil service structure, we have some positions built in for consumers, not just stipends, but salaried positions. But we always look to at each position to see if it can generate other revenue. SAMHSA grants are precious dollars, because there are few strings attached. The Medi-Call positions have many more restrictions.

> 5.1.c **RESOLUTION (MHB-2002-29)**
> **Be it resolved that the Mental Health Board send a letter to Robert Cabaj, M.D., Director, Community Mental Health Services and Community Behavioral Health Services, stating that the Board has reviewed the federal SAMHSA (Substance Abuse and Mental Health Services Administration) renewal application for fiscal year 2002/03 funds and that the Board gives its full approval and support to this grant. (Passed unanimously.)**

5.2 Report from the Program and Services Committee

Ms. Wilson reported as follows: The MHB began doing the program reviews as part of the program performance score for the Quality Management Department of CMHS about nine years ago. At that time, CMHS did not have any other ways of determining client satisfaction. Now there is a Client Satisfaction Survey developed by CMHS, an ombudsman, a SF Clients Rights Advocacy Program, a Consumer Council, and an anonymous consumer complaint line, so there are many avenues for consumers to provide direct input to CMHS about the programs.

With the way we are scoring the program reviews currently, they are buried in the rest of the findings of the program performance score. At a meeting with the committee in July, Quality Management suggested that the MHB Program Review be an independent process, rather than a process that results in a score that gets buried in the overall rating. The Independent MHB Program Review report would go directly to Bob Cabaj. This would also allow the MHB to create its own time frame for doing the reviews rather than needing to fit the CMHS schedule. The MHB Program Review would provide an overall review with recommendations directly to Dr. Cabaj.

The Program and Services Committee had a meeting following this one to which it outreached to the mailing list for MHB meetings, and to all of the CMHS contract programs to hear public input on this potential change in how we do program reviews. The resolution before you is a result of that meeting.

Mr. Stinson: Program reviews are a core component of what we do. I think the Committee has come up with a good proposal. But this is a change in how we do program reviews and I want to make sure that people feel comfortable with the change and want to encourage your questions and comments.

Ms. Brown: How many programs will we be reviewing? Mr. Stinson: We'll still have board members review the programs and we'll still be doing one or two. But instead of being part of the CMHS review process this will give us the potential for broader impact and for more flexibility in the reviews.

Mr. Shipley: I was on the Mental Health Board for five years. I've just recently started coming back to meetings as a consumer activist. Having done these reviews for 5 years, it's very nice to see that we've cut the strings and see that we are doing the reviews independently. Under state statues we are not supposed to be ruled by our mental health system. We are supposed to be independent so we can advocate for clients. I personally felt restrained and restricted on what I could report on when following CMHS guidelines and the guidelines the Board developed in the past.

Ms. Brooke: By doing our reviews between September and February, the reviews will be in to Dr. Cabaj in time to affect the contract process.

> 5.2.a **RESOLUTION (MHB-2002-30): Be it resolved that the Mental Health Board review 10-20 Community Mental Health Service programs annually, from September through February, independently and separately from the Quality Management Department program reviews. (Passed unanimously)**

3.0 PRESENTATION: Emergency Response Plan and Post Traumatic Stress Disorder
Mr. Stinson: One of our priorities which we set at the end of last year was the aftermath of September 11, 2001. It was clear to the Executive Committee that this was the meeting to focus on that priority. There are two themes we'll be focusing on tonight:

> 1. How has our city has dealt with crises in the past and how it will deal with them in the future? God forbid that something would happen here like what happened in New York, but we need to be prepared.

2. What are the effects of Post Traumatic Stress Disorder?

Ms. Stangby: I've been an emergency nurse for 25 years and have been focused on disaster work for 10 years. Until we started planning for possible Y2K consequences, I didn't realize the importance of mental health services. But we found out in our preparation that people are needing someone to talk to. You never know what's going to cause someone to become anxious or frightened. I've been working with LaDonnis Elston of CMHS on school violence and work place violence issues.

San Francisco has a wonderful plan for disaster. Can we handle something of the scale of what happened in New York? No, no city is really ready for that. But New York did a good job and we will, too. One of the key things is the volunteers who come forward and give of themselves.

There is a myth that when an earthquake happens, people will start looting. But the contrary is true, mostly people rise to the occasion and do things they didn't know they could do.

SFGH is part of the City emergency plan. So is every hospital, the San Francisco Fire Department, and the San Francisco Police Department. We have a disaster command system. There is a commander, planners, plus operations people to do the work, and finance people to figure out how to pay for it.

In San Francisco, especially at SFGH, we activate our disaster plan at the drop of a hat. And we activate a lot as practice, so when something major happens we'll be ready. We had a major power failure a year and a half ago at SFGH when the alternative power failed. If we weren't used to activating our plan it would have been a disaster, but it wasn't because we knew what to do.

A year ago today, we activated our disaster plan. SFGH is the safety net hospital. We had quite a few people needing mental health services. We had people scared to death who needed to talk to someone.

We have learned so much from what happened in New York and Washington, D.C. One issue was that when phones and computers went down in New York, no one knew what patients were at what hospitals. There was no central database.

In San Francisco, we have a family reception center at 23rd and Potrero. There are pay phones there. Pay phones operate even when there is a power failure. But cell phones won't. How many people here have an out of state contact for disasters? The idea is to have someone out of the area you can call, and then friends and family can call that person instead of instead of jamming the phone lines in the disaster area. All of this goes back to one foundation. and that is personal preparedness. It really does make a difference.

Something interesting happened after September 11th. The George Jewett foundation asked what can we do here in case of a disaster. What Mrs. Jewett wanted to do was to have some resource for people in San Francisco showing them where to go if there was a bombing. What we did was prepare a pocket guide that is waterproof and tear proof, which lists all police and fire stations. Plus there is information on what to do about basic issues, and how to become prepared. It's also printed in Spanish and Chinese. We produced and distributed 280,000 copies in April. We're grateful to the Jewetts for doing this.

Dr. Koller: According to the DSM there are four components to PTSD

1. trauma, fear, horror
2. physical hyperarousal
3. intrusive symptom, intrusive memories
4. significant avoidance

PTSD is what people tend to think of in terms of stress disorders, but there is a wide range of stress disorders. Immediately following a disaster like 9/11 you can see mild transient disorders in just about everybody. Almost everyone has a little bit of trouble sleeping, drinking a little more than usual, or being more irritable. But these symptoms tend to drop away and have only minimal interference with your life. The acute period is 1-3 months after the traumatic event. But then in most people a lot of the symptoms drop off.

In about 30% of people, the PTSD becomes chronic and the symptoms stay. After about three years, therapy doesn't help at all. Therapy will help speed the process of healing, but it won't take you anywhere that you weren't going to get to anyway. The vast majority of people who develop PTSD, have 2-3 co-morbid disorders, such as substance abuse or mental health problems. Anxiety tends to precede PTSD while depression and substance abuse tends to come after PTSD.

There's been a push recently for psychiatric debriefing right after a disaster. Outcome studies show mixed results. Debriefing can actually make things worse. The most valuable part of debriefing is triage, helping find out who are the people who are going to need help. Debriefing can help in terms of education, telling people how not to make it worse, such as: Don't drink. Do get back to your normal routine.

Women and Hispanics are 1.5 to 2 times more likely to develop PTSD. 5% of men and 10% of women tend to have PTSD according to a1996 study. Another risk factor is having had a stressful life in the year before a major trauma. Men tend to become more symptomatic after rape than women. Women become more symptomatic after criminal assaults. Men experience more trauma after natural disasters.

Victims of child abuse or serious neglect are much more at risk for PTSD.
The younger someone is, the fewer psychological defenses they have to help them.
Latency age kids (5-12) tend to be less reactive than younger children or teenagers.

People with a history of anxiety or mood disorders are more at risk. Less education or lower socioeconomic class puts a person more at risk. If someone dissociates at the time of the trauma, that's a predictor of PTSD. Often people don't even know they are dissociating. Symptoms include time slowing down, out of body experiences, and tunnel vision. Dissociating offers survival in short run, but it will cost you in the long run. It prevents healing and working through. your feelings. Immigrants are likely to be more at risk if they have poor social support in this country, and if they have had to escape from a war zone. People with a history of one trauma, are likely have 2 or more traumas. Being traumatized predisposes you for trauma.

Mr. Shipley: I spent half the day watching the memorials today. My diagnosis is PTSD from early childhood. What do you say about someone who has been traumatized, being retraumatized by other violence sequences or things that disrupt the normalcy of your life? I have been in a depression for a year. I had a very close friend who was so traumatized by September 11th that last October she committed suicide. I'm not as active as I was, and am more depressed and having a hard time getting out of it.
Dr. Koller: One of the things that gets lost is flexibility and the ability to adapt. You can get focused on yesterday instead of today.

Ms. Walker: Someone could be in a situation where they can be traumatized in much the same way again and again. Dr. Koller: Yes, we see women who were abused as children are also abused by boyfriends and husbands. The average woman leaving an abuser who goes into a domestic violence shelter goes back to her husband about six times before leaving for good.

Current trauma can rekindle old trauma. After 9-11 we saw Vietnam vets coming in much more than we did after the Gulf War. The old stuff we haven't worked through, that's what's going to pop up. The way these symptoms pop up is not direct. You see someone drinking more, or abusing their spouse. Or there are somatic complaints. This is especially true with kids. They don't say, I'm stressed, they just hit their brother.

The first thing we tell people after a disaster is to turn off your TV. A little information is helpful. But to see the image over and over can be traumatizing.

In New York City, about 8-10% of people have PTSD related to the disaster. People also have sustained stress disorder and chronic stress. You see sleep problems, depression, startle responses, and avoidance behaviors. How much shame a person feels seems to play role in PTSD. It clearly fits with having been abused as a kid. Negative self-esteem can leave you vulnerable.

Dr. Del Zotto: What about secondary PTSD? Dr. Koller: Yes, it's very powerful. Being married to someone with PTSD, such as a combat veteran, the PTSD can get passed on to the spouse and children. If dad gets explosively angry, he becomes the source of the trauma.

Dr. Del Zotto: In the Latino community, people who lived in war zones, can pass the message on to their kids, Don't trust anyone. There is a deep resistance to trusting other people in the second generation of kids who come from war zones.

Mr. Nizzardini: You mentioned the volunteers who come forward in the disaster. It's a difficult task to coordinate volunteers. How do you do that?

Ms. Stangby: The Volunteer Center of San Francisco is excellent. They are responsible for taking in volunteers and matching them with requests from providers. The hardest thing is turning away volunteers. The Volunteer Center has a huge data bank of people. AmeriCorps wants to come back into San Francisco and strengthen disaster programs, and we're hoping that works out. Volunteers can hinder the effort. Volunteers were a hindrance in New York and Oklahoma City and many people who were injured and killed were volunteers. The only person who died in Oklahoma City was a volunteer nurse who rushed in to help but was unprepared and was hit by falling rubble and was killed.

Ms. Walker: What is avoidance disorder? Dr. Koller: It's not so much a disorder but a cluster of symptoms, which include avoiding crowds, or avoiding things they used to do. For example, there are combat veterans who shop at Safeway very early in the morning. They are in and out before anyone knows they are there.

Dr. Koller: Keith Armstrong says that after 20 years of doing this work on trauma, we're learning not to get in the way of people, so they can heal themselves. For acute trauma, the more delimited it is, the more therapy can help. After 30 years of living with trauma, it becomes so intermixed with so many life issues. Healing is really more up to the client than anything we have to offer.

We've learned not do debriefing right after the event, but to give a little time. Then we offer it, but don't require it. We use it for education and triage rather than therapy.

Mr. Dorsey: The last three to four weeks the radio has been constantly broadcasting about children being abducted, and bodies being found. I found myself getting so upset. The radio seemed to be having an orgy of these stories. I don't watch TV because I can't handle the images. Should I listen to the radio or turn it off?
Dr. Koller: It's a good idea to turn it off. Perhaps watch the Discovery Channel instead. We do believe in exposure therapy in PTSD, but we are very careful who we do that with. We're very careful not to over expose people.

Ms. Shaffer: Which organizations are involved in the disaster plan? Ms. Stangby: The schools, Red Cross, Department of Public Works, Department of Parking and Traffic, Police Department, Fire Department, Health Department, Recreation and Parks Department, Emergency Medical Systems, Council on Aging. Pretty much everyone.

Ms. Shaffer: I just know that many schools are not prepared. They are among the worst-structured buildings. I've been working for six years to get a disaster plan together in the school in Oakland where I work, and I'm still working on it. Ms. Stangby: In San Francisco, the School District has a very good disaster plan. They just hired one of the premier disaster planners in the county, Stasha Weisgold. In Alameda County, you can contact CARD, Collaborating Agencies Responding to Disasters.

4.0 DIRECTORS REPORTS

4.1 Report from the Director of Community Mental Health Services

Ms. Wang: There was a cut by the City to the Mental Health Board budget. What we did was to cover that in our SAMHSA grant application. That's part of what I'm saying about those grant funds being precious. They are more flexible, as long as you can justify why you want to fund things in that grant. We definitely did not want the MHB to have a budget reduction.

Other cuts also took place in the budget. The cuts are not nearly as bad as originally proposed. When we first started looking at budget cuts, it was very painful. We fared very well, but at the tail end, we ended up losing some positions. The State budget has cuts for children's mental health.

I also wanted to let you know that we are in the process of re-engineering how our 22 outpatient clinics do their work. We want to deal with the delays in access to care. There is a shortage of staff, a turnover of staff, and an inability to recruit psychiatrists. The end result of those shortages is a delay in getting services started for new clients. Or a delay in getting urgent care.

We're looking at an advanced access model of service delivery, being able to see your doctor or clinician on the day you ask for help. Also being able to get the evaluation sooner, on the same day or the next day, rather than 4 days or 6 days or even weeks. This is going to be a difficult process. We need to have our clinics take care of their backlog. This is a whole other way of doing business with existing resources. We're hoping between now and February of 2003 that we will be able to transition our clinics. We are confident that this model when implemented will make for much better service. and that both consumers and providers will be happier.

CMHS has been providing disaster response and trainings for ten years now since the Loma Prieta earthquake. We've build up a cadre of staff who have been trained. We provide emergency response regularly. Like in the case of a hotel fire. We work with the Red Cross. We go out to shelters. We see these smaller incidents as an opportunity to keep in practice. They are a chance for people to use their training so they will remember and will be ready if there is a larger incident. We were not prepared for Loma Prieta and we learned our lesson.

Ms. Wang distributed the Directors written report:

Budget Update
The Board of Supervisors added back the $500,000 in cuts to CMHS that were distributed among the fee-for-service hospitals, IMDs, and the Private Provider Network, and a 1% COLA for non-profit contractors was also approved. However, the subsequent negotiations with the unions were not successful and because some unions unexpectedly did not support the retirement pick-up, the Department was required to make some additional reductions. In Mental Health, our Private Provider Network was decreased by $100k, and our salary savings budget was increased by $30k.

L-Facility Evaluation.
It is no secret that CMHS wants to reduce institutional and costly service use. To that end, Quality Management sought to identify factors that contribute to longer community tenure for discharged Long-Term Care Facility clients. Using a cohort of 128 clients who were discharged from L facilities in 1997 and 1998, we looked at Billing and Information System (BIS) data, clinical information from charts, interviews with clients and a focus group with staff. So what did we learn? . We found that over a two-year period, 80% of those 128 clients did not return to an L-facility. Of those who returned to an L-facility during this 2-year period, one third returned within three months of discharge and that two-thirds of recidivists returned within the first year.

Staff focus group data reinforced the knowledge that clients are most vulnerable during transitional time upon discharge. We also found that substance abuse, physical health problems, behavioral problems and lack of adequate daily living skills were some of the factors that correlated with recidivism. It also appears that men, younger people and African Americans are at greater risk for recidivism and this calls for more targeted and culturally competent services following discharge from an L-facility. There was also some evidence that board and care homes were an important source of community stability for many clients. The clients also reported benefiting from a variety of support including staff continuity during and after transition to the community and in general, for intensive case management type services including the SPR's. Clients also expressed the need for better medication management and faster access to medical professionals including psychiatrists and nurses.

Behavioral Health. The planning for integrating Community Mental Health Services and Community Substance Abuse Services has begun. The Goal and Definition that will guide this work are:

Goal: Integrate the administrative, clinical and fiscal functions of CMHS and CSAS into a comprehensive behavioral health delivery system by July 1, 2005 to improve clinical outcomes, maximize resources and increase client, provider and employee satisfaction.

Definition: Behavioral Health is an integrated, inter-disciplinary system of care that approaches individuals, families and communities as a whole and addresses the interactions between psychological, biological, sociocultural and environmental factors.

The planning process will be guided by an executive committee and will include approximately 10 working committees and several focus groups of consumers, community leaders, and providers involved in behavioral health services.

Ms. Wang then introduced Dr. SenGupta.

Mr. SenGupta: I'm here tonight to present a brief report on a three-year study Kevin McGirr and I have been doing. We studied the results of getting people out of long term care and into the community in the mid to late 90's. That was a period when CMHS was making a major effort to reduce institutional bed utilization. The Mental Health Rehabilitation Facility had been built and opened. Assertive Community Treatment teams had been established.

Dr. SenGupta then used overheads to make the following points:

TITLE OF THE STUDY
Identifying Factors That Contribute to Longer Term Community Tenure for L-Facility Discharged Clients.

PURPOSE
To identify possible factors that contribute to longer term community tenure of L-Facility discharge clients.

STUDY VARIABLES
Demographic, diagnostic, service assignment and utilization, residential placement, substance use, medical problems, cognitive impairment, individual ability to complete Activities of Daily Living, vocational involvement, social engagement, behavioral problems, psychiatric symptoms, medication effectiveness and compliance.

STUDY PERIOD
Discharge period: January 1, 1997 - December 31, 1998
Tracking period: 24 months post-discharge.

METHODOLOGY
A mixed method study design using CMHS Billing Information System, chart review, semi-structured client interview, staff focus group.

SUMMARY FOR MHB PRESENTATION
23% returned within 24 months and one-third of them returned in the first 3 months.

African American, male, and younger clients were most at risk of recidivism. (As a result of this study, we applied for a State grant for an IMD African American focus program.)

Recidivists were more impacted by physical health issues, substance abuse, psych symptoms, behavior problems.

Recidivists were less engaged in daily living activities, social or vocational activities, and less compliant with medications.

Clients endorse medications, especially more recent medication, complained of sedative side effects, and were often dissatisfied with support provided during medication changes and for side effects.

Community tenure had positive association with residential care facility placement.

Clients expressed strong desire and appreciation for social contact and caring relationships.

Clients had limited understanding about the need for primary care.

Clients often expressed strong endorsement for cigarette smoking especially as a recreational activity. This increases other health risks.

Providers identified housing, family support, more linkage and overlap between community and institutional providers as contributors to longer term community tenure.

Ms. Leung: Did you study the reasons why the clients returned to the long-term facility so soon? Either the treatment was too short or the case management was inadequate.
Dr. SenGupta: Many of our study group came from Canyon Manor or Crestwood and had been there for years and years. They would then spend three months in the Mental Health Rehabilitation Facility. Those clients were not ready to transition to the

community. The MHRF philosophy at the time was unless you have exposure to outside world, you won't be able to cope with it. So they expected some to come back very quickly.

Mr. Nizzardini: What about the findings on the African American clients?
Dr. SenGupta: The African American clients were in the older age groups, and they had had a lot of trauma in their lives, and the maximum dissociation from society. Initially we had a hard time interviewing older African American clients. They were afraid to consent to be interviewed. But once we broke through that barrier, we found that the services they received in prior years, were not culturally competent, and even the baseline issues were not handled very well. Those things are changing.

The full report on this study is 50 pages. It's a public document and anyone can request it. We are also preparing an hour presentation with PowerPoint slides. Kevin and I would be glad to present that to the full Board or to the Program and Services Committee if you like.

3.2 Report from the Executive Director of the Mental Health Board

Ms. Brooke: The Police Crisis Intervention Training is set for four times in the next year: October 7 - 10th, January 13th - 16th, April 21st - 24th, and July 21st - 24th.

Ms. Walker: Bridgett, I heard you speak before the Budget Committee of the Board of Supervisors, and you spoke so well that the Supervisors who were there actually listened to you. You did a beautiful job!

6.0 PUBLIC COMMENT

None.

There being no further business, the meeting was adjourned at 8:29 p.m.

SAN FRANCISCO MENTAL HEALTH BOARD

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MEETING OF THE MENTAL HEALTH BOARD

Wednesday, October 9, 2002
1380 Howard, Room 537
6:30 p.m.

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AGENDA

Public comments will be taken for each agenda item.

1.0 CALL TO ORDER AND CONSENT CALENDAR (5 min)

For discussion and proposed action

1.1 Call to Order and Announcements from the Chair

1.2 Consent Calendar (Attachment A)

1.2.a PROPOSED ACTION: Be it resolved that the minutes of the Mental Health Board meeting of September 11, 2002, be approved as submitted.

1.2.b PROPOSED ACTION: Be it resolved that the Mental Health Board grants leaves of absence for the meeting of October 9, 2002, to the following members: None

2.0 PRESENTATION: **Program Review Training.** (45 min)

Several former board members will present their experiences with program reviews. An overview of the format of Program Reviews will be provided by the Executive Director.

3.0 DIRECTORS REPORTS (30 min)

For discussion

3.1 Report from the Director of Community Mental Health Services
A report on the activities and operations of Community Mental Health Services, including budget, planning, policy, and programs and services.

3.2 Report from the Executive Director of the Mental Health Board
A report including updates and announcements regarding the activities and operations of the Board.

4.0 MENTAL HEALTH BOARD COMMITTEES (20 min)

For discussion and proposed action

4.1 Report of the Chair of the Board and Executive Committee

The chair will report discussions and actions of Executive Committee.

5.0 NEW BUSINESS (10 minutes)

Suggestions for future agenda items or issues the Board might consider looking into.

6.0 PUBLIC COMMENT (10 minutes)
This is an opportunity for members of the public to address the Mental Health Board on items of interest to the public that are within the subject matter jurisdiction of the Mental Health Board. Additionally, public comments will be taken for each agenda item.

This agenda and all attachments can be viewed at: www.sfgov.org/mental_health. Agendas and attachments are also available at the Mental Health Board Office, 1380 Howard Street, Suite 510, telephone 255-3474.

DISABILITY ACCESS

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2. Meetings are held at 1380 Howard Street (corner of 10th Street), in Room 537. The closest accessible BART station is the Civic Center station, at the intersection of Market, Grove and Hyde Streets. The closest Muni Metro station is the Van Ness Station. Accessible MUNI lines serving the location are the 9 San Bruno, 47 Van Ness, and the 72 Haight/Noriega. For more information or updates about the current status of MUNI accessible services, call (415) 923-6142. For information about Paratransit Services call (415) 351-7000.

3. The main entrance to 1380 Howard is accessible to wheelchairs. Elevators, doorways, restrooms, and the meeting room are wheelchair accessible. Accessible curbside parking has been designated on Grace Alley which runs on the opposite side of the building from 10th Street.

4. In order to assist the City's efforts to accommodate persons with severe allergies, environmental illnesses, multiple chemical sensitivity or related disabilities, attendees at public meetings are reminded that other attendees may be sensitive to various chemical based products. Please help the City accommodate these individuals.

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The ringing of and use of cell phones, pagers, and similar sound-producing electronic devices are prohibited at this meeting. Please be advised that the Chair may order the removal from the meeting room of any person(s) responsible for the ringing or use of a cell phone, pager, or other similar sound-producing electronic devices.

KNOW YOUR RIGHTS UNDER THE SUNSHINE ORDINANCE

Government's duty is to serve the public, reaching its decisions in full view of the public. Commissions, boards, councils and other agencies of the City and County exist to conduct the people's business. This ordinance assures that deliberations are conducted before the people and that City operations are open to the people's review. For more information on your rights under the Sunshine Ordinance (Chapter 67 of the San Francisco Administrative Code) or to report a violation of the ordinance, contact:

Donna Hall
Sunshine Ordinance Task Force
City Hall, Room 244
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102-4689
Telephone: (415)554-7724
Fax: 4(15) 554-5163
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MENTAL HEALTH BOARD
ATTACHMENT A
October 9, 2002

CONSENT CALENDAR

All items on the Consent Calendar are handled through a single vote. There will be no discussion unless a member requests it, in which case the item will be removed from Consent Calendar and discussed. Additional names may be added to the leave of absence resolution during the meeting.

1.2.a **PROPOSED RESOLUTION: Be it resolved that the minutes of the Mental Health Board meeting of September 11, 2002, be approved as submitted.**

1.2.b **PROPOSED RESOLUTION: Be it resolved that the Mental Health Board grants leaves of absence for the meeting of October 9, 2002, to the following members: none.**

SAN FRANCISCO MENTAL HEALTH BOARD

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UNADOPTED MINUTES
Mental Health Board

Wednesday, October 9, 2002
1380 Howard Street, Room 537
San Francisco, CA 94103
6:30 p.m.

BOARD MEMBERS PRESENT: Andrea Leung, L.C.S.W., A.C.S.W. (Acting Chair); Bridgett Brown; Augusta Del Zotto, Ph.D.; Bob Douglas; Carol Knight; chance martin; Toye Moses, Ph.D., M.P.H.; Rick Nizzardini, L.C.S.W., J.D.; Dorothy Shaffer, R.N., N.P., M.S.N., Kate Walker; Idell Wilson; Sandy Yuen; Dennis Yun, M.S.W.

BOARD MEMBERS ON LEAVE: Ted Stinson (Chair); Rose Chung for Supervisor Aaron Peskin.

BOARD MEMBERS ABSENT: Robyn Buckins;

OTHERS PRESENT: Linda Wang (Director of Adult Services, Community Mental Health Services); Emeric Kalman; Mark Adamek (San Francisco Network of Mental Health Clients); Helynna Brooke (MHB Executive Director); Rich Snowdon (MHB Administrator)

1.0 CALL TO ORDER AND CONSENT CALENDAR

1.1 Call to Order and Announcements from the Chair

The meeting was called to order at 6:36 p.m. by Andrea Leung, Acting Chair.

1.2 Consent Calendar

1.2.a **RESOLUTION (MHB-2002-31): Be it resolved that the minutes of the Mental Health Board meeting of September 11, 2002, be approved as submitted. (Passed unanimously.)**

1.2.b **RESOLUTION (MHB-2002-32): Be it resolved that the Mental Health Board grants leaves of absence for the meeting of October 9, 2002, to the following members: Ted Stinson. (Passed unanimously.)**

2.0 PRESENTATION: Program Review Training

Ms. Knight: I want to extend my thanks to everyone on the Program and Services Committee. We accomplished quite a bit in preparing for the new MHB program reviews. You have the packet for program reviews in front of you on the table.

I'm very excited that this is the first time the Mental Health Board will have an independent review. This is our review of the centers and will be submitted to the mental health system.

Once again I want to thank my co-chair and all the committee members. Thanks to Helynna for putting the packet together. Hopefully you've decided which centers you want to review. Now Helynna will explain the packet

Ms. Brooke: Here is an overview of the process:

1. You choose the program you want to review.
2. I send a letter to the program director to explain what the review is about.
3. Then I call the program director.
4. I find out the best times for a review; when the most clients will be there.
5. We ask the program to post notices about the review and to let clients know about it. Clients are also informed that participation in the review is voluntary and doesn't impact their treatment.
6. Then you go out to the program to do the review. Reviews usually take between two and four hours each.

When you go out on your first review, one of the MHB staff will go with you. The staff will help with any problems that come up and will be there as a resource, but will not participate in the review itself.

At the program, we want to see that our program review notices are posted in places that are easy to see. We want to see that the patient's rights poster is very visible, also the grievance procedure poster. We ask for a private office for the interviews so they can be confidential.

Then you proceed to ask each client who volunteers, the questions in the client satisfaction survey.

Depending on the number of clients volunteering, you'll hopefully be doing 4-8 interviews at each program. Some interviews take longer, some are shorter depending on how much the client wants to talk.

You'll also want to interview the Director and perhaps a staff member, in order to get information about the program.

Doing these reviews will give you more direct knowledge of the system and that means you'll be stronger advocates when talking with the members of the Board of Supervisors about mental health services.

With regard to conflict of interest, we ask you not to review programs where you are or have been: a client, a family member of a client, a staff person, a volunteer, or a close friend of someone who works there. We want to avoid even the appearance of a conflict. We want the reviews to be seen as being fair and complete.

A client may share with you that they are really unhappy with their medication or therapist. Encourage them to talk with the program director or call the grievance person at CMHS. If you interview 4-5 clients and they are all saying the same thing about the same therapist, then write that down, because that's an important pattern to report.

If there is something that you find that is not good, please call the office and we will take it to CMHS administrators to resolve. Once we found a very serious problem between two clients and we were able to get clinicians to step in and resolve the situation.

We will be doing the reviews between now and February. In February the contracts are renewed and our reviews will provide input for CMHS in the contracting process.

Ms. Walker: It's a good idea to ask the clients if you can take down notes. And if they say no, then don't. But if they say something that you really need to write down, ask them again, and they'll probably say okay.

Each facility should have a patients' rights poster, and if someone is in need of help, you can encourage them to call Consumer Rights Advocates (552-8100).

mr. martin: I do a lot of advocacy outside the scope of the Mental Health Board, am I to keep any findings I run across confidential to the purposes of this body?

Ms. Brooke: Yes, our role is to facilitate getting things fixed within the system. We don't want clients to feel that their comments are out there in public. But if you hear from a number of clients that they would like a place to drop in at 2 a.m. in the morning or on weekends when they are in crisis, then that's more a system issue and a policy issue and we can talk about it in a more public way.

Dr. Moses: The last time I did my program review was five years ago. The key is to be able to establish confidence with the clients. Otherwise you won't get a good review. Make sure you are not going in as a policeman. Take the time to establish confidence and trust, then they will open up to you if they know you are there to help.

Mr. Nizzardini: My only concern is using anecdotal information to make a case for something when there may have been different findings by different board members.

Ms. Brown: Programs don't always have four or more clients for you, since it is up to the consumer to choose to do the interview or not.

Mr. Douglas and Ms. Leung then did a role play of a client satisfaction interview.

Ms. Brown and Ms. Walker did a second role play.

Dr. Moses: It's good to paraphrase to make sure answers are clear. Also it's good to be sensitive to when the interview is getting too long for the person.

mr. martin: You can show the questionnaire to the client and ask , Is there anything I missed?

Ms. Brown: I like to ask, Is there anything I haven't asked you that you'd like to say about the program? This is a key question.

Ms. Knight: You might want to let them know at the beginning that there are 20 questions, and it's okay to stop if it feels like it's going on too long. But sometimes they're very glad to talk in detail.

Mr. Nizzardini: I think it's always helpful to remember to say that the client's ability to receive services is in no way affected by this interview, that it's voluntary and they can stop anytime they want.

3.0 DIRECTORS REPORTS

3.1 Report from the Director of Community Mental Health Services

Ms. Wang: I'm here representing Bob Cabaj tonight. He's in Sacramento at a meeting of the California Mental Health Directors Association.

Budget Update. There is the possibility of additional cuts in the City budget for FY02-03 given that revenues are not keeping up with expectations. Capital projects have already been frozen. The budget process for FY03-04 is beginning this month and at this point there is already a projected deficit in the City budget of $150 Million for FY03-04. We're not hearing great news from the State either. We're starting the planning for the next fiscal year. The budget is practically a 12-month process now. We haven't gotten the instructions yet, but the writing is on the wall that we'll be asked to make cuts. We're hearing that the City is going to start slowing down expenditures.

Behavioral Health. The planning for integrating Community Mental Health Services and Community Substance Abuse Services is moving ahead. Barbara Garcia has sent a letter to all programs announcing the start of the planning process. The Executive Committee for the integration has hired a consultant who will facilitate 12 focus groups for the purpose of getting input from all the stakeholders. The Executive committee has also decided that there will be 12 subcommittees. The CMHS and CSAS Executive Staff are now meeting jointly once a month.

Adult and Older Adult All-Staff Meeting. The CMHS Adult & Older Adult Systems of Care held the first all-staff meetings in mid-September. A total of 700 staff attended. Future directions were presented, including the integration of Community Mental Health and Community Substance Abuse Services into Behavioral Health Services, the need to improve linkages of institutionalized clients to community services, and the advanced access model for outpatient care. The meeting provided opportunities for staff to learn from colleagues on topics of common concern. Staff and/or consumers nominated the following individuals who received recognition awards for outstanding performance: Helen Thomas, Sandi Robison, Eric Seeley, Pamela Laverty, Jacqueline Moskus, Carolina Padron, Susanne Killing, JoAnn Thomson, Troy Williams, Charles Windham, and Diep Vuong. The meetings were well attended and positively received.

San Francisco Police Department. CMHS Executive Staff and Helynna Brooke, Executive Director of the Mental Health Board, met with Deputy Chief Heather Fong (recently appointed Deputy Chief for Administration) and other members of the SFPD Command Staff. At the meeting, SFPD and CMHS reaffirmed their joint commitment to the continuation of the Police Crisis Intervention Trainings as well as the Police Procedures Orientation for CMHS staff. The third intervention training took place last week. A date for the next police procedures orientation for CMHS staff has not been set. The rigorous evaluation of the trainings will also continue. This will include a follow-up meeting with the May, 2002 and October, 2002 classes early in 2003 and one-on-one evaluation follow-up interviews with the October, 2001 class and the May, 2002 class.

California Department of Mental Health Site Review. The Department of Mental Health Annual Site Review of the San Francisco Mental Health Plan also took place last week. The report will arrive in 30 to 60 days.

Outcomes. The State Department of Mental Health has decided to make major changes to the instruments and methodology used to collect outcomes data for both adults and children and youth. It is anticipated that these changes will go into effect in May, 2003. In the meantime, the counties have the option of stopping the current data collection effort. San Francisco plans to take advantage of this option for the Adult and Older Adult systems of care; the Children, Youth and Family System of Care will continue with part of the current data collection. A letter to this effect is being sent to the programs participating in the outcomes project. We will keep you informed as plans for the new systems are announced.

Annual System Orientation. CMHS conducted the third annual system orientation on September 25 and 26. The orientation was the same on both days. This orientation is primarily focused on new staff, but is also attended by a number of other staff as well as a number of individuals from the other sections in the Department of Health and other city departments and agencies who want to know more about how CMHS operates.

Advanced Access. In the previous fiscal year, over 18,000 individuals received outpatient care from Community Mental Health Services. CMHS, in order to improve access to outpatient care for adults and older adults, is embarking in October, 2002 on piloting aspects of the advanced access model for managing demand for services and the resources to meet that demand. Training of clinic leadership will take place in October, followed by the testing of new strategies by clinics to streamline the process for accessing services. We want to be able to deliver car in a timely way.

We want to improve our ability to help clients transition from acute services to community services. Too many clients do not make the transition and then end up back in the hospital.

Dr. Moses: Do you have any update on the hiring of a new Executive Director at the Family Mosaic Project?

Ms. Brooke: They have found two people who they are very excited about, but I don't know the final decision.

Dr. Moses: I wonder if we can hear about specific programs that are doing good work, for example, the Rehabilitation Facility.

Ms. Wang: The MHRF has about 140 clients, and for the last couple years because of hiring freezes throughout the city, they were having a hard time getting their staff vacancies filled. They have to have a certain number of staff to meet licensure and to ensure safety.

Dr. Moses: I remember that the purpose of that building was to bring clients home from out-of-county placements.

Ms. Wang: We were able to bring people back to San Francisco, which increases their ability to reintegrate into the community. And the length of stay has diminished because people are returning to the community.

We do have some clients there who love it there, because the facility is beautiful, so they would like to stay, because it's better housing than they can find in the community.

Ms. Walker: In terms of the combining of mental health and substance abuse, is there a financial savings involved?

Ms. Wang: We don't know at this point, because we're just starting, but we are going to be looking at what efficiencies can be created as we integrate the services.

Mr. Douglas: I don't understand how the advanced Access works.

Ms. Wang. Take for example a clinic that has a waiting period of three weeks before they can schedule an intake for a new client, and another 3-4 weeks wait for a medication evaluation. They have a reservoir of appointments scheduled on into the future.

The reservoir remains about the same. It's always about 3-4 weeks. It remains fairly constant how long the waiting period is for the intake appointment and the medication appointment. So the idea is that with a lot of extra effort, a clinic will try to not only take care of the appointments they already have scheduled, but then try to make sure that new people are taken care of right away, so that we do today's work today. We respond to the demands that come into the clinic today, instead of putting it off. The idea is to get rid of the reservoir of people waiting and once we're caught up to stay caught up. But in the catch up period you've got to work really hard, cut out staff meetings, or work overtime in order to take care of all those appointments.

3.2 Report from the Executive Director of the Mental Health Board

Ms. Brooke: I want to thank Augusta and Kate for coming to meet with the State auditors when they were here to review CMHS. It was a very important meeting.

We're in the middle of the third Police Crisis Intervention Training. Kate has been attending all of the training. We have 31 officers attending. Monday was on general psychological disorders. Tuesday the officers went out for visits to the clinics, then came back to hear a panel of consumers and family members talk about their experiences with mental illness. Kate was part of the panel as a consumer and Carol as a family member. Stamp out Stigma, a group of consumers who do many presentations each year also participated.

Augusta, Dennis, and Mike Wise, along with all the panelists had lunch with the officers to provide opportunity for further questions and discussion. In the afternoon, the officers went back out for more site visits, and then on to PES and the inpatient wards. Most of the time they are just dropping people off at PES. We wanted them to see all the different levels of care.

Today, was another day of lecture on children's issues, mental illness and cultures, active listening, 5150 process, and suicide intervention. Tomorrow, they are going to do role playing. Augusta, Kate, and Idell are going to be the stars in the role playing tomorrow. Then at 4 p.m. there will be a graduation ceremony and reception. Chief Sanders, Tom Ammiano, and Leland Yee will be there.

Mr. Douglas: How are the officers chosen?

Ms. Brooke: A resolution was passed by the Board of Supervisors last year that three officers from each station each shift would come to the training. Sgt. Mike Sullivan sends requests out, and he and Officer Mike Cowhig call officers. We get a lot of volunteers. Some captains detail people to attend.

The goal is to train all of the 1,200 first responders in the Police Department.

We're hearing about how the training is working in practice. Two officers were called to respond to an incident regarding a mentally ill person. After assessing the situation, the first officer said, Let's grab him. The second officer had been through the training, and said, Let me try something first. Within a matter of minutes he had talked the person down, and they were able to take him quietly and cooperatively to Psychiatric Emergency Services with no one getting hurt. The first officer then wanted to know how to do that. The officers are very good at learning from each other.

The next PCIT sessions will be January, April, and July of 2003.

Mr. Kalman: Does the Police Department have a psychiatric unit?

Ms. Brooke: No, and we don't want that actually. They have a psychiatric liaison officer who is on 24 hour call for other police officers. The goal is to have the entire police department understand issues of mental illness.

Mobile crisis has seen a dramatic increase in calls from the police since starting the PCIT.
We've developed an excellent working relationship between the Police Department and CMHS.

Mr. Kalman: The Police Department used to have three people on their psych unit. And it was defunded maybe 8 years ago. In my personal experience, I saw how this works when the police officer makes a 5150, and he contacts his psych officer about what to do and what not to do. A one-day or two-day training is not enough.

mr. martin: I remember when the psych unit was defunded. There's a lot of debate back and forth. Having a police psychiatric unit can imply criminalization of mental illness. The PCIT is just to give the department overall training to help officers deal competently with behavioral issues. The Police Department's command and control paradigm did not work for people who were hearing voices. These people could not respond to the police officers orders, and they were winding up getting hurt. The PCIT is based on a program that was started in Memphis.

4.0 MENTAL HEALTH BOARD COMMITTEES

4.1 Report of the Chair of the Board and Executive Committee

5.0 NEW BUSINESS

Dr. Moses: I'd like to invite the director of the Mental Health Rehabilitation Facility to up-date us about that program.

6.0 PUBLIC COMMENT

Mr. Adamek: I have some important information for the Board. I'm the acting president of the San Francisco Network of Mental Health Clients. I'm here to let you know that the Network will probably have to close its doors at January 1 if we do not get more funding. I'd like to commend our board and staff who are working as hard as they can. My Co-Executive Director has taken a pay cut to help keep the doors open.

Spiritmenders Community Center is therefore in jeopardy. I expect *Voices at Bay* to remain financially solvent. It's my request that if anyone here knows anyone who can help us, please contact me or Julia Diaz at Spiritmenders (552-8565) We'd appreciate it. What's unique about us is that we were founded by consumers and we are consumer run.

Dr. Moses: Thank you for announcing this. Where are you getting funding currently and are you a nonprofit?

Mr. Adamek: Yes, we are a nonprofit, so we can take tax exempt donations. We are currently subsisting on the last few dregs of a grant from the San Francisco Foundation, but they won't fund us any more. We sent a proposal to the local Presbyterian Synod in Berkeley. Thanks for your consideration tonight. If you want to come by and visit us at Spiritmenders, we're open Monday though Friday from 11 a.m. to 5 p.m.

There being no further business, the meeting was adjourned at 8:30 p.m.

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SAN FRANCISCO MENTAL HEALTH BOARD

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MEETING OF THE MENTAL HEALTH BOARD

Wednesday, November 13, 2002
1380 Howard, Room 537
6:30 p.m.

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AGENDA

Public comments will be taken for each agenda item.

1.0 CALL TO ORDER AND CONSENT CALENDAR (5 min)

For discussion and proposed action

1.1 Call to Order and Announcements from the Chair

1.2 Consent Calendar (Attachment A)

1.2.a PROPOSED ACTION: Be it resolved that the minutes of the Mental Health Board meeting of October 9, 2002, be approved as submitted.

1.2.b PROPOSED ACTION: Be it resolved that the Mental Health Board grants leaves of absence for the meeting of November 13, 2002, to the following members:

2.0 PRESENTATION: AN OVERVIEW OF SUNSHINE REGULATIONS (45 min)

Paul Zarefsky from the City's Attorney's Officer will provide an overview of Sunshine Regulations applicable to the Mental Health Board.

3.0 DIRECTORS REPORTS (30 min)

For discussion

3.1 Report from the Director of Community Mental Health Services
A report on the activities and operations of Community Mental Health Services, including budget, planning, policy, and programs and services.

3.2 Report from the Executive Director of the Mental Health Board
A report including updates and announcements regarding the activities and operations of the Board.

4.0 MENTAL HEALTH BOARD COMMITTEES (20 min)

For discussion and proposed action

4.1 Report of the Chair of the Board and Executive Committee
The chair will report discussions and actions of Executive Committee.

4.1 a PROPOSED ACTION: Be it resolved that the Mental Health Board commends and thanks KQED for producing "Hope on the Street." (Attachment B)

4.2 Public Education Committee

4.2 a PROPOSED ACTION: Be it resolved that the Mental Health Board commends the City and County of San Francisco for Developing Wellness Centers in the Schools (Attachment C)

5.0 NEW BUSINESS (10 minutes)

Suggestions for future agenda items or issues the Board might consider looking into.

6.0 PUBLIC COMMENT (10 minutes)

This is an opportunity for members of the public to address the Mental Health Board on items of interest to the public that are within the subject matter jurisdiction of the Mental Health Board. Additionally, public comments will be taken for each agenda item.

This agenda and all attachments can be viewed at: www.sfgov.org/mental_health. Agendas and attachments are also available at the Mental Health Board Office, 1380 Howard Street, Suite 510, telephone 255-3474.

DISABILITY ACCESS

1. American Sign Language interpreters and/or a sound enhancement system will be available on request. Please contact Ladonnis Elston at (415) 255-3444 (voice) or (415) 255-3449 (TTD) 5 days before the meeting. Large print copies of the agenda will be made available upon request; please call (415) 255-3474.

2. Meetings are held at 1380 Howard Street (corner of 10th Street), in Room 537. The closest accessible BART station is the Civic Center station, at the intersection of Market, Grove and Hyde Streets. The closest Muni Metro station is the Van Ness Station. Accessible MUNI lines serving the location are the 9 San Bruno, 47 Van Ness, and the 72 Haight/Noriega. For more information or updates about the current status of MUNI accessible services, call (415) 923-6142. For information about Paratransit Services call (415) 351-7000.

3. The main entrance to 1380 Howard is accessible to wheelchairs. Elevators, doorways, restrooms, and the meeting room are wheelchair accessible. Accessible curbside parking has been designated on Grace Alley which runs on the opposite side of the building from 10th Street.

4. In order to assist the City's efforts to accommodate persons with severe allergies, environmental illnesses, multiple chemical sensitivity or related disabilities, attendees at public meetings are reminded that other attendees may be sensitive to various chemical based products. Please help the City accommodate these individuals.

POLICY ON CELL PHONE, PAGERS, AND ELECTRONIC DEVICES

The ringing of and use of cell phones, pagers, and similar sound-producing electronic devices are prohibited at this meeting. Please be advised that the Chair may order the removal from the meeting room of any person(s) responsible for the ringing or use of a cell phone, pager, or other similar sound-producing electronic devices.

KNOW YOUR RIGHTS UNDER THE SUNSHINE ORDINANCE

Government's duty is to serve the public, reaching its decisions in full view of the public. Commissions, boards, councils and other agencies of the City and County exist to conduct the people's business. This ordinance assures that deliberations are conducted before the people and that City operations are open to the people's review. For more information on your rights under the Sunshine Ordinance (Chapter 67 of the San Francisco Administrative Code) or to report a violation of the ordinance, contact:

Donna Hall
Sunshine Ordinance Task Force
City Hall, Room 244
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102-4689
Telephone: (415)554-7724
Fax: 4(15) 554-5163
E-mail: Donna_Hall@ci.sf.ca.us

Citizens interested in obtaining a free copy of the Sunshine Ordinance can request one from Ms. Hall, or by printing Chapter 67 of the San Francisco Administrative Code from the internet at: **www.sfgov.org/sunshine.htm**

To view Mental Health Board agendas and minutes, you may visit the MHB web page at: **www.sfgov.org/mental_health**. You may also go to the Government Information Center at the Main Library at Larkin and Grove in the Civic Center. You may also get copies of these documents through the MHB office at 255-3474.

Lobbyist Registration and Reporting Requirements

Individuals and entities that influence or attempt to influence local legislative or administrative action may be required by the San Francisco Lobbyist Ordinance [SF Campaign & Governmental Conduct Code 2.100] to register and report lobbying activity. For more information about the Lobbyist Ordinance, please contact the San Francisco Ethics Commission at 30 Van Ness Avenue, Suite 3900, San Francisco, CA 94102; telephone (415) 581-2300; fax (415) 581-2317; web site www.sfgov.org/ethics.

SAN FRANCISCO MENTAL HEALTH BOARD

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MENTAL HEALTH BOARD
ATTACHMENT A
November 13, 2002

CONSENT CALENDAR

All items on the Consent Calendar are handled through a single vote. There will be no discussion unless a member requests it, in which case the item will be removed from Consent Calendar and discussed. Additional names may be added to the leave of absence resolution during the meeting.

1.2.a **PROPOSED RESOLUTION: Be it resolved that the minutes of the Mental Health Board meeting of October 9, 2002, be approved as submitted.**

1.2.b **PROPOSED RESOLUTION: Be it resolved that the Mental Health Board grants leaves of absence for the meeting of Novemer 13, 2002, to the following members: none.**

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MENTAL HEALTH BOARD
ATTACHMENT B
November 13, 2002

PROPOSED RESOLUTION (MHB-2002-xx)

COMMENDING AND THANKING KQED FOR PRODUCING AND AIRING "HOPE ON THE STREET"

WHEREAS, the problem of the homeless mentally ill on our streets is one that has not been well understood by the public, leading to a general sense of hopelessness and frustation about the issue, and

WHEREAS, California has provided funding for assertive and innovative outreach and case management programs which are proving themselves to be more effective than any approach attempted in the past, and

WHEREAS, people suffering from mental illness say the stigma against mental illness is often worse than the illness itself, and whereas, this stigma prevents an estimated 80 percent of mentally ill individuals from seeking treatment, and

WHEREAS, KQED through its program BayWindow, has produced an engaging, revealing, and sensitive documentary called "Hope on the Street," and

WHEREAS, "Hope on the Street" provides the uplifting message that there is hope for the mentally ill, even those living on the street, and that many of them can lead stable, fulfilling lives when given access to quality care, and

WHEREAS, this program will be shown throughout the country, will be used for inservice trainings for mental health professionals, and for years to come will be shown directly to the homeless mentally ill, inspiring them to seek treatment and stay with it, so they can live productive and healthy lives, now, therefore

BE IT RESOLVED, that the San Francisco Mental Health Board commends KQED for its commitment to producing "Hope on the Streets," a program of the very best quality and of great social value, and be it

FURTHER RESOLVED, that the Mental Health Board expresses its sincere gratitude to everyone who participated in creating, producing, and promoting "Hope on the Street," including most especially:

Michael Isip, Producer
Elizabeth Pepin, Associate Producer
Robert O'Geen, Editor
Sevda Eris, Outreach Coordinator
Sue Ellen McCann, Executive Producer

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MENTAL HEALTH BOARD
ATTACHMENT C
November 13, 2002

PROPOSED RESOLUTION (MHB-2002-xx)

COMMENDING THE CITY AND COUNTY OF SAN FRANCISCO FOR DEVELOPING WELLNESS CENTERS IN THE SCHOOLS

WHEREAS, needs assessment surveys have shown that there is an urgent need among the students of the San Francisco School District for physical and mental health services, and,

WHEREAS, in 2000, Youth Making a Change, of Coleman Advocates for Children and Youth, in response to a wide scale survey they conducted among students, developed a proposal for Wellness Centers to be established at the high schools, and

WHEREAS, the San Francisco Unified School District, the Department of Children, Youth, and Their Families, and the Department of Public Health came together to solve the significant challenges in establishing a new inter-departmental program, and to develop funding, and

WHEREAS, the City and County of San Francisco in school year 2000/01 established Wellness Centers at seven of the city's largest high schools, bringing together a wide range of integrated health, behavioral, substance abuse, and support services, and

WHEREAS, the Wellness Center model has numerous significant advantages, including that it:

Impacts a significant number of youth.
Is integrated into each school site.
Provides linkages to long-term health care providers.
Increases the use of existing community health resources and services such as community clinics.
Builds on existing resources and avoids duplication of services.
Provides health education and awareness for students, parents, teachers, and administrators.
Empowers youth to access health services, learn about community resources, and become educated health consumers.
Encourages healthy behaviors, and taking responsibility for one's health.
Actively prevents substance abuse.
Actively prevents health crises, including mental health crises.
Provides suicide prevention and depression screening.

Provides case management.
Provides positive family support.
Positively impacts academic performance, and

WHEREAS, both the administration of the programs and the delivery of services has been rated as outstanding by preliminary evaluations based on services delivered to 6,200 students, and

WHEREAS, the Youth Commission held a hearing April 18, 2002, on the Wellness Centers, where young people from around the city testified as to the value of the Centers and the urgent need for them, and whereas, the Youth Commission is strongly in support of the Wellness Centers and has developed a recommendation for expanding and improving the Centers, and

WHEREAS, the cost of providing services is only $356 per year per student served directly, and only $119 per student served indirectly, and

WHEREAS, the Wellness Centers are specifically designed to prevent medical and mental health crises from developing among the student population, and

WHEREAS, crisis prevention is a key cost-effectiveness strategy of the City and County of San Francisco, and

WHEREAS, the public schools are a key location for doing the most effective prevention work, and

WHEREAS, City staff continue to work at bringing in new funding possibilities for the Wellness Centers, through new billing strategies, by leveraging funding from state and federal sources, as well through grants from private foundations, and

WHEREAS, the Wellness Centers help make San Francisco more youth-friendly and more family-friendly, and

BE IT RESOLVED, that the San Francisco Mental Health Board commends Youth Making a Change for initiating and advocating for the Wellness Centers, and for the efforts they've continued to make so that the Centers could be successful, and

BE IT FURTHER RESOLVED, that the Mental Health Board commends all the students at the high schools where the Wellness Centers are located for welcoming the Centers to their campuses, for supporting them, and for making good use of them, and

BE IT FURTHER RESOLVED, that the Mental Health Board commends the over 30 community based organizations which have partnered with the Wellness Centers to provide onsite services and linkages, and

BE IT FURTHER RESOLVED, that the Mental Health Board commends the McKesson Foundation for funding the peer-to-peer outreach services which have now become part of the Wellness Center program, and

BE IT FURTHER RESOLVED, that the Mental Health Board expresses its sincere gratitude to the Mayor, the Board of Supervisors, and all participating City departments, City commissions, and staff for creating a remarkably successful collaborative effort that San Francisco can be very proud of, and

BE IT FURTHER RESOLVED, that the Mental Health Board commends City staff for continuing to look at ways to increase staffing and improve space at the current Wellness Centers, to establish Centers or equivalent service delivery method, to serve the additional ten high schools currently without them, and

BE IT FURTHER RESOLVED, that the Mental Health Board strongly recommends, that high school students be provided specifically with the following services, whether through the Wellness Centers or through an alternative service delivery strategy, especially given that issues of sexual and reproductive health and pregnancy prevention are such urgent, complex, and challenging issues for students:

a) STI testing and counseling;
b) birth control and pregnancy prevention counseling and pregnancy testing,
c) access to condoms,
d) assertiveness training on dealing with issues of dating, sexuality, drug abuse, peer pressure, and decision making skills, and

BE IT FURTHER RESOLVED, that the Mental Health Board strongly recommends that the position of Wellness Center Coordinator be structured so that the conversations Coordinators have with students and the notes they make on those conversations be held as confidential, so students will be able to talk freely and tell the whole truth about their situation, and

BE IT FURTHER RESOLVED, that the Mental Health Board strongly recommends that everything possible be done to keep the Centers administratively streamlined and without unnecessary demands for paperwork, and

BE IT FURTHER RESOLVED, that the Mental Health Board recommends that the City develop a plan for making sure that there is easy access to health services, in an age-appropriate manner, for all of the school children in San Francisco, and we believe this would be one of the most powerful and effective public health initiatives the City could ever undertake.

SAN FRANCISCO MENTAL HEALTH BOARD

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MEMORANDUM

TO: Mental Health Board Members

RE: Wellness Center Resolution

DATE: November 7, 2002

In your Board packet for November 13th you received a copy of the Wellness Center Resolution from the Public Education Committee.

Enclosed is an updated version adding some new information from the Youth VOTE 2002 report which we just received, and making some changes after we consulted with the Public Health Committee of the Youth Commission and with the School District.

The changes are in italics.

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MENTAL HEALTH BOARD
ATTACHMENT C
November 13, 2002

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UPDATED VERSION

PROPOSED RESOLUTION (MHB-2002-xx)

COMMENDING THE CITY AND COUNTY OF SAN FRANCISCO AND *THE SAN FRANCISCO UNIFIED SCHOOL DISTRICT* FOR DEVELOPING WELLNESS CENTERS IN THE SCHOOLS

WHEREAS, needs assessment surveys have shown that there is an urgent need among the students of the San Francisco School District for physical and mental health services, and,

WHEREAS, in 2000, Youth Making a Change, of Coleman Advocates for Children and Youth, in response to a wide scale survey they conducted among students, developed a proposal for Wellness Centers to be established at the high schools, and

WHEREAS, the San Francisco Unified School District, the Department of Children, Youth and Their Families, and the Department of Public Health came together to solve the significant challenges in establishing a new inter-departmental program, and to develop funding, and

WHEREAS, in school year 2000/01, the City and County of San Francisco and *the San Francisco Unified School District* established Wellness Centers at seven of the city's largest high schools, bringing together a wide range of integrated health, behavioral, substance abuse, and support services, and

WHEREAS, the Wellness Center model has numerous significant advantages, including that it:

Impacts a significant number of youth.
Is integrated into each school site.
Provides linkages to long-term health care providers.
Increases the use of existing community health resources and services such as community clinics.
Builds on existing resources and avoids duplication of services.
Provides health education and awareness for students, parents, teachers, and administrators.
Empowers youth to access health services, learn about community resources, and become educated health consumers.

Encourages healthy behaviors, and taking responsibility for one's health.
Actively prevents substance abuse.
Actively prevents health crises, including mental health crises.
Provides suicide prevention and depression screening.
Provides case management.
Provides positive family support.
Positively impacts academic performance, and

WHEREAS, both the administration of the programs and the delivery of services has been rated as outstanding by preliminary evaluations based on services delivered to 6,200 students, and

WHEREAS, the Public Health Committee of the Youth Commission in conjunction with the Public Health Committee of the Board of Supervisors held a hearing April 18, 2002, on the Wellness Centers, where young people from around the city testified as to the value of the Centers and the urgent need for them, and whereas, *the Public Health Committee of the Youth Commission has voiced* support for the Wellness Centers, including expanding and improving the Centers, and

WHEREAS, the results of Youth VOTE 2002, with 8,000 students from 22 high schools participating, show that:

a. 90% said yes in response to the question: Is confidentiality (privacy) important to you when accessing health services?

b. 80% said yes in response to the question: Should Wellness Centers/school health services provide STD and pregnancy testing?

WHEREAS, the cost of providing services is only $356 per year per student served directly, and only $119 per student served indirectly, and

WHEREAS, the Wellness Centers are specifically designed to prevent medical and mental health crises from developing among the student population, and

WHEREAS, crisis prevention is a key cost-effectiveness strategy of the City and County of San Francisco, and

WHEREAS, the public schools are a key location for doing the most effective prevention work, and

WHEREAS, City and *School District* staff continue to work at bringing in new funding possibilities for the Wellness Centers, through new billing strategies, by leveraging funding from state and federal sources, as well through grants from private foundations, and

WHEREAS, the Wellness Centers help make San Francisco more youth-friendly and more family-friendly, now therefore, BE IT RESOLVED, that the San Francisco Mental Health Board commends Youth Making a Change for initiating and advocating for the Wellness Centers, and for the efforts they've continued to make so that the Centers could be successful, and

BE IT FURTHER RESOLVED, that the Mental Health Board commends all the students at the high schools where the Wellness Centers are located for welcoming the Centers to their campuses, for supporting them, and for making good use of them, and

BE IT FURTHER RESOLVED, that the Mental Health Board commends the over 30 community based organizations which have partnered with the Wellness Centers to provide onsite services and linkages, and

BE IT FURTHER RESOLVED, that the Mental Health Board commends the McKesson Foundation for funding the peer-to-peer outreach services which have now become part of the Wellness Center program, and

BE IT FURTHER RESOLVED, that the Mental Health Board expresses its sincere gratitude to the Mayor, the Board of Supervisors, *the School District*, and all participating City departments, City commissions, and staff for creating a remarkably successful collaborative effort that San Francisco can be very proud of, and

BE IT FURTHER RESOLVED, that the Mental Health Board commends City staff for continuing to look at ways to increase staffing and improve space at the current Wellness Centers, to establish such Centers or *other health and wellness service delivery models* at the additional ten high schools currently without them, and

BE IT FURTHER RESOLVED, that the Mental Health Board strongly recommends that *all* high school students be provided specifically with the following services, whether through the Wellness Centers or through an alternative service delivery strategy, especially given that issues of sexual and reproductive health and pregnancy prevention are such urgent, complex, and challenging issues for students:

a) STI testing and counseling *upon demand,*
b) pregnancy testing *upon demand,*
c) birth control and pregnancy prevention counseling,
d) access to condoms,
e) assertiveness training on dealing with issues of dating, sexuality, drug abuse, peer pressure, and decision making skills, and

the Mental Health Board commends the School District for everything it is already doing in these areas, and

BE IT FURTHER RESOLVED, that the Mental Health Board strongly recommends that the position of Wellness Center Coordinator be structured so that the conversations Coordinators have with students and the notes they make on those conversations *will be held as completely confidential,* so students will be able to talk freely and tell the whole truth about their situation, and

BE IT FURTHER RESOLVED, that the Mental Health Board strongly recommends that everything possible be done to keep the Centers administratively streamlined and without unnecessary demands for paperwork, and

BE IT FURTHER RESOLVED, that the Mental Health Board recommends that the City develop a plan for making sure that there is easy access to health services, in an age-appropriate manner, for all of the school children in San Francisco, and we believe this would be one of the most powerful and effective public health initiatives the City could ever undertake.

SAN FRANCISCO MENTAL HEALTH BOARD

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UNADOPTED MINUTES
Mental Health Board

Wednesday, November 13, 2002
1380 Howard Street, Room 537
San Francisco, CA 94103
6:30 p.m.

BOARD MEMBERS PRESENT: Ted Stinson (Chair); Bridgett Brown; Augusta Del Zotto, Ph.D.; Bob Douglas; Carol Knight; Rick Nizzardini, L.C.S.W., J.D.; Rose Chung for Supervisor Aaron Peskin; Dorothy Shaffer, R.N., N.P., M.S.N., Kate Walker; Idell Wilson; Sandy Yuen; Dennis Yun, M.S.W.

BOARD MEMBERS ON LEAVE: Andrea Leung, L.C.S.W., A.C.S.W.; Toye Moses, Ph.D., M.P.H.

BOARD MEMBERS ABSENT: Robyn Buckins; chance martin.

PRESENTER: Paul Zarefsky, Deputy City Attorney

OTHERS PRESENT: Linda Wang (Director of Adult Services, Community Mental Health Services); Emeric Kalman; Mickey Shipley (San Francisco Network of Mental Health Clients, Mental Health Association, Citywide Alcoholism Advisory Board); Helynna Brooke (MHB Executive Director); Rich Snowdon (MHB Administrator)

1.0 CALL TO ORDER AND CONSENT CALENDAR

1.1 Call to Order and Announcements from the Chair

The meeting was called to order at 6:34 p.m. by Ted Stinson, Chair.

Mr. Stinson: We have a new Board member, Joel Leubkeman.

Mr. Luebkeman: I am holding a Family Member Seat, and was appointed by Supervisor Leland Yee. I live on the western side of the city, in Mira Loma Park. I'm excited to be involved in the Mental Health Board.

Ms. Brooke: We now have 17 Board members which is the first time in my tenure as Executive Director that we have had a full Board!

1.2 Consent Calendar

1.2.a **RESOLUTION (MHB-2002-33): Be it resolved that the minutes of the Mental Health Board meeting of October 9, 2002, be approved as submitted. (Passed unanimously.)**

1.2.b **RESOLUTION (MHB-2002-34): Be it resolved that the Mental Health Board grants leaves of absence for the meeting of November 13, 2002, to the following members: Andrea Leung, Toye Moses. (Passed unanimously.)**

2.0 PRESENTATION: Sunshine Ordinance Training

Mr. Zarefsky: What I'd like to do is a brief overview of the aspects of the Sunshine Ordinance which are the most relevant to the Mental Health Board, specifically relating to open meeting laws. There are also Sunshine laws that relate to public records, which are handled more by your staff than by Board members.

There are three topics I want to start with:

1. What is a meeting. Virtually everything in the Sunshine Ordinance is keyed into a meeting.
2. Agendas
3. Public Comment.

First, why do we have open meeting laws? One reason is that it tends to promote responsive government if you have input from members of the public. It provides officials with more information and input than they would otherwise have.

Second, it's important that we have clean government, so things are out in the open, and private deals aren't being made.

Third, you have to make your decisions in public and be accountable, in order to have principled government.

Fourth, we need these laws to have accountable government.

Sometimes there are things that seem overly burdensome, but that's part of the price you pay for the good things you get from the open government laws.

What happens if you violate these laws? What's most likely to happen is you get hauled before the Sunshine Task Force. It can be embarrassing and bad publicity. There are other sanctions that come into play, including in an extreme case, criminal violation. Or actions of your board could be rescinded. But that is not of such concern to an advisory body.

What is a meeting? A meeting occurs whenever the majority of a policy body come together at the same time in the same place. A committee of a policy body is a policy body in and of itself. A majority of the Mental Health Board is nine members.

Even if you had three vacancies, a majority would still be nine members. It's keyed to the number of seats, not the number of seats currently filled.

This is a fairly open ended definition. It's not limited to a meeting like tonight. You might have nine of you together discussing some other issue.

What about a meal gathering? You decide to get together at a restaurant before your Board meeting, and that counts as a meeting itself. The Sunshine Ordinance was sensitive to the possibility of commissioners meeting before or after a meeting and taking care of business.

If you have a retreat, that is still a meeting.

This is only half the definition of a meeting, based on physically getting together.

There are also seriatim meetings. Seriatim is a Latin word, and it indicates serial meetings. Commissioner A gets together with Commissioner B. Then Commissioner B talks to Commissioner D. You don't physically have a majority of the people together, but you do have a majority of the members of the policy body talking together formulating a position on a substantive issue.

What about e-mail? You have an idea. You want to e-mail the other Board members. That's a violation because you're having communication among the majority of members of the policy body, and it's not an agendaized meeting. The public doesn't have an opportunity to participate. The same is true for conference calls by phone, or letters sent.

The exception is logistical issues like scheduling and other necessary administrative decisions.

If a majority of your Board members attend a regional or statewide or national conference, that's okay, provided a majority doesn't collectively discuss the business of this Board. It's okay for a majority to show up at the meeting of another organization, as long as you are not the participants of the meeting but attendees.

It's okay for a majority to attend a social gathering that has nothing to do with the Board. For example, if majority of the Board members attend a wedding. However, if you have a social gathering yourself, or is hosted by you, then that's a passive meeting. There are very limited sunshine requirements regarding a passive meeting.

Can two or three Board members get together to discuss an issue? That's okay. But if a note is passed around to all the commissioners at a meeting, then that note needs to be made public.

The Sunshine rules hold for a majority of a committee getting together.

Seriatim communication is okay if it doesn't involve a majority of the members.

You need to have nine votes to pass any issue at your Board meetings. Only a majority of the policy body can make a decision for that body. Again, this is tied to the total number of seats for the Board, not the number of seats currently filled.

The agenda is what guides the meeting. You are allowed to cover what's on the agenda, and you're not allowed to cover anything not on the agenda. It has to be enough to guide a member of the public so they know if they want to attend or not.

It's okay to make announcements that are not listed on the agenda. Board members can propose things they want on future agendas. That's not a matter for discussion or action.

Any policy body has the ability to call a special meeting with very short time requirements.

There has to be an opportunity for public comment on all agenda items. If it's an action item, the public comment has to come before a decision or vote. There also has to be an opportunity for general public comment on items under your jurisdiction.

Here are some basic rules about the rights members of the public have with regard to public comment:

1. The right to equal treatment. You have to give everyone the same amount of time. If you have a lot of speakers, you have to decide in advance how much time each person is going to get.

2. A right to comment anonymously. It's fine to ask a speaker to state their name for the record, but you can't require it. Sometimes people don't want to identify themselves.

3. A right to criticize the policy body or its members. You can't cut someone off because they are saying bad things about your body or your members. There are freedom of speech issues here as well as meeting laws. This applies to your own members as well. There are very broad free speech rights. But there is no right to get a response from the body.

As far as time goes, three minutes is the general amount of public comment. You can cut it back if you have lots of people. And you have to give them a reasonable amount of time to speak on the topic. If it's a complicated issue, half a minute is not enough.

If a member of this body forms their own informal group of advisors, that's a passive meeting body. You have to have it open to the public; you have to put it on the website. If you have an agenda and the public asks for it, you have to give it to them. There is no right of public comment.

Mr. Stinson: I'm assuming that Board members cannot comment during the public comment period.

Mr. Zarefsky: I'm not sure of the answer to that. My general feeling is no. The reason is that there is a general rule that the Board is not supposed to discuss issues not on the agenda. Taking off your Board member hat and putting on your public hat circumvents the rule. There is no law on this. There is also a rule that says Board members have all the first amendment rights of any citizen.

Mr. Stinson: How do you differentiate between making a proposal to put something on a future agenda and a discussion?

Mr. Zarefsky: If you discuss whether an item should be on the agenda, that's okay, But if you get into the substance of the issue, then that's not okay.

Ms. Brooke: What about speakers answering questions from public?

Mr. Zarefsky: I think that's okay. I've always taken the position that when you have a presentation, that's not public comment. Now in terms of the give and take, I think that's fine because you're talking about the inherent nature of the presentation is such that you want the give and take. I think it's important that it's done in a way that it's not skewed, that one group doesn't get its point of view included.

Ms. Brooke: During our presentations we take questions from the Board members first, then we take questions from the public.

Mr. Zarefsky: That's including the public more. But you have to treat them equally.

Mr. Kalman: What about the order of the agenda?

Mr. Zarefsky: If you know you are going to change the order of the agenda at the beginning of the meeting, state that at the beginning. But any item can be taken at any point after the beginning of the meeting.

Mr. Nizzardini: Do you include MHB staff as part of the quorum? Mr. Zarefsky: No, because they don't have the right to vote. They are there to take care of much of the work. In San Francisco, we have this huge number of advisory bodies and commissions, which is great in terms of involving the public. But most of you have full time jobs or busy lives and you can't do all the work yourselves.

Ms. Walker: Who can say how something is put on the agenda? Mr. Zarefsky: Your bylaws may state how things get on agenda, or it may just be a matter of historical precedent. The majority of the body has the right to say we want something on the agenda. In that context, you could have a vote on whether to put something on a future agenda.

Ms. Brooke: At our Retreat and Reception we serve food. Mr. Zarefsky: You don't have to serve food to the public. If you are meeting in a restaurant, the public has to be able to come in to attend for free.

Ms. Brooke: Are there limitations on how the staff can communicate with Board members. Mr. Zarefsky: You have the same considerations. If you have a bunch of Board members talking to each other through the staff, that's a seriatim meeting through the staff.

Ms. Brooke: What about staff collecting a list of priorities. Mr. Zarefsky: When it's very informational or one dimensional or in the nature of a form, that's okay. For example, if you are asking for three topics Board members want covered at a retreat.

Ms. Yuen: Does the Sunshine Ordinance apply to organizations that get money from CMHS? Ms. Ruffin: I think our contracts with providers include that they have to be in compliance with the Sunshine ordinance.

Mr. Kalman: If there is a violation, should you go to the Sunshine Task Force or the Ethics Commission?

Mr. Zarefsky: Go to the Sunshine Task Force, and talk to Donna Hall. She's very helpful in working things out for members of the public or City Government.

3.0 DIRECTORS REPORTS

3.1 Report from the Director of Community Mental Health Services

Ms. Ruffin: I'm the Mental Health Director, and I will be retiring in January. I will be at your retreat in December, but I will probably not be at the January meeting. So this is my last MHB meeting.

Linda Wang is here with me tonight to help provide continuity in this transition. Both of us are here for Dr. Bob Cabaj who is the new Director of Behavioral Health. He has had a conflict with this meeting night.

Dr. Cabaj's written report was distributed:

Budget Update. The FY03-04 Budget Process has begun. Currently, the Department is determining the cost of maintaining the existing level of services in FY03-04, which includes calculating the cost of contractor and civil service COLAs, as well as identifying any structural revenue or expenditure problems that have surfaced during the year. Preliminary estimates from the Mayor's Office indicate the City is facing a deficit situation, and budget reductions may be necessary to balance the City's budget. It is too early to quantify the impact to the Department.

Transgender Life Care Project. The Transgender Life Care Project, a collaboration between UCSF and CMHS and funded by a grant from Substance Abuse and Mental Health Services Administration, is now fully operational. The primary aim of this project is to provide mental health care to transgender and questioning individuals at a primary care setting. This is being offered onsite at the Castro-Mission Health Center. In addition, outreach and support groups are offered at the UCSF Health Studies for People of Color program on Bush Street across from St. Francis Hospital. For more information on this project and services offered, please call Joanne Keatley, MSW, Project Director at (415) 476-2364.

Advanced Access. Trainings of outpatient clinic leadership on advanced access is underway. Outpatient clinics have submitted plans for eliminating any waits for intake appointments by December 15, and for testing a variety of strategies to improve access.

The target date for full implementation of advanced access is February 1, 2003. The goal is to improve timely access to assessment and treatment services.

Children's System of Care. On October 21, 2002, the Work Group on Community-Based Systems of Care from the American Academy of Child & Adolescent Psychiatry presented a symposium on "Community Mental Health Strategies For America's Children" in San Francisco. The symposium presented the San Francisco Children's System of Care as an exemplary model in the development of children's systems of care. The CMHS-CYF staff involved in the day-long event as presenters were: Sai-Ling Chan-Sew, Cynthia Billups,. Irene Sung, Esperanza Echavarri, Al DeRanieri, Steve Banuelos, Albert Eng, Roger Woo, George Fouras and Shelly Frank.. Parents and Youth from the Youth Task Force also attended the discussion groups in the afternoon to provide their perspectives. The symposium was attended by over 150 child psychiatrists and CYF providers. The next day on October 22nd, Irene Sung led an institute on children's system of care and wraparound services, and led site visits to Family Mosaic Project and Edgewood Children's Center.

Mr. Stinson: Is there anything more you can say about the Budget?

Ms. Ruffin: The budget is going to be bad. We will be getting the full instructions from the Mayor shortly. We will have to figure out within our Departmental budgets how to do salary increases we're committed to through the unions. Just a 3% COLA is $3 million. And in terms of our contract agencies, there will not be a COLA , and we'll probably have to find any COLA within the budget. So we've got those two problems going in.

Ms. Wang: There is some question about the Children's System of Care. Fifty percent of the funding is gone already, and the remainder may be cut. For the AB 2034 program, we got a 6% cut this year. And that's going to be the case for next year.

Ms Ruffin: We had one fortunate thing with regard to the Children's System of Care. Sai-Ling has be able to get a federal grant for the CSOC , which we can hopefully use to replace the state money that is lost.

Mr. Nizzardini: Having seen the news about California leading the states in budget deficits, is that a foreshadowing of how much you're going to have to cut?

Ms. Ruffin: Realignment was a change in the way mental health services were funded about ten years ago. It moved mental health out of the state general fund and into state sales tax and the Vehicle Licensing Fees. But we have to be vigilant that the legislature doesn't undo that.

Ms. Wang: There is some interest in developing a legislative committee to re-examine realignment. So they may be edging toward a revision of the way that works.

Mr. Stinson: What are the implications of additional funds being provided by Prop N passing?

Ms. Ruffin: Proposition N is the Care not Cash ordinance. I haven't heard about how that's going to work. AB 1421 allows counties to do pilot projects on involuntary outpatient treatment. There is no funding attached. Implementation of AB 1421 will be determined by the Board of Supervisors. It's not in the hands of the Department of Public Health. There has to be some attestation that providing AB 1421 services will not take away from other existing services. There is some concern about whether money will be moved from General Assistance into involuntary outpatient treatment.

There is a concern is that the GA funds are not very big. GA is not a big amount of money for people receiving it, and it's not a very big amount for treatment either. The GA dollar is the last bit of housing money for many of the people who aren't living out on the streets. If that money is going to move to services, what will happen in terms of housing? The Department of Public Health will implement whatever the City decides.

Mr. Douglas: Do you know who will be handling the post Prop N thing?

Ms. Ruffin: I'm assuming that the Department of Human Services will be the lead agency. But I don't know how the Supervisors will work it.

I very much encourage the Board to consider this issue for a future agenda.

Thank you all so much for all the work you've done, and all the support you've given me. I've been the Mental Health Director for 7 years, which is a new record. Thank you for all your dedication and everything you do.

Mr. Shipley: I wanted to follow up on Jo's comments about AB 1421. Even though it is written into law, there are several stop gaps. It has no funding. It also says, no county can remove funding from existing services to fund involuntary treatment. I am a consumer activist and former member of this Board. The Board needs to be very vigilant about any actions the Board of Supervisors might take and if there is any action coming down to the Health Commission. There are at least 12 statutes under WIC that governs this legislation and two of them involve this Board.

3.2 Report from the Executive Director of the Mental Health Board

Ms. Brooke: I want to highlight Jo's role in finding a location in this building for Mike Cowhig, the psychiatric liaison officer for the SFPD.

Ms. Ruffin: I want to thank you, Helynna, and the Board, for all the work you've done with the Police Department around the crisis intervention training. The relationship between CMHS and the Police Department is the best I've seen it in all my 36 years in mental health..

4.0 MENTAL HEALTH BOARD COMMITTEES

4.1 Report of the Chair of the Board and Executive Committee

Mr. Stinson: Last year was my first retreat with the Board and it was one of the best experiences I had last year. First, it was a solid block of time to spend together as a MHB. We get fed well. You will learn a lot from the day. You will be contributing to the direction we go in next year.

One of the reasons we've been successful is that we came out of that retreat with a pretty good sense of what's important to people. We have limited time, so it's important that we as a Board decide how to focus in on our key issues.

Mr. Luebkeman: Is there a facilitator for the retreat? What percentage of the Board attends?

Ms. Brooke: Some years we've had a facilitator and some not. For the past two years it's worked well not to have a facilitator. The Board has engaged more with each other without the facilitator. Usually almost all Board members attend.

Mr. Nizzardini: I'm not got to be at the retreat because I have a commitment I made even before coming on the Board. I'm very sad that I will not be there, and I wish you well, but I have been calling in ideas for priorities.

A couple suggestions I have for priorities include: 1) integration and creation of behavioral health services, and 2) the issue of homelessness. I have a concern after going to the focus group yesterday about the number of stakeholders who were not at the table in this change to a behavioral services model. How is that working?

Ms. Wang: We've put together an intensive system of committees that will be working over the next few months. It's seven or eight committees. There are also focus groups. There is a plan that in either January or February a report will go to the Health Commission on how the process is going.

Ms. Ruffin: Barbara Garcia is also working on how the advisory Board system will work into this transition.

Mr. Nizzardini: I've heard that there will be a reduction in the number of Boards during this integration.

Ms. Brooke: There is a significant difference between the Mental Health Board and the other advisory bodies. We are a state mandated board. There is a requirement for us to exist. So we'd want to be very involved in this process, but I'm not sure how much we can change.

Ms. Knight: I've heard rumors that clients with drug and alcohol problems will be able to drop in at clinics at any time.

Ms. Ruffin: Nothing is worked out yet. But the idea is that we have such a high percentage of our clients with substance abuse problems who need to be getting better treatment, and the same is true on the other side with substance abuse clients needing mental health treatment. So we want people to be able to get a good range of treatment wherever they enter the system.

The implementation for this is not scheduled until July 2005, so we are just starting the discussions for this.

Ms. Knight: My main concern is that a lot of clients have fought to get away from alcohol and drugs. And if they are going to be in the same clinics with people who are still dealing with those issues, if they are going to be in that same atmosphere, the impact of that would be a serious issue.

Ms. Ruffin: Those are important points we want to make sure get fed into this process.

Mr. Stinson: If you have other thoughts on goals, please send them in to Helynna.

Mr. Shipley: I wanted to respond to Rick's concerns. Under state law, the local Mental Health Boards have a duty to review and evaluate needs and advise on needs, etc. That is your duty under WIC.

Mr. Stinson: Next we have a resolution regarding Hope on the Street, a hour-long program produced by KQED and aired recently. I saw it and thought it was fantastic. It was both inspiring and at times inspiring in a sad way. The documentary put together by KQED. It's a series of about half dozen vignettes, profiles of members of the community who have struggled with mental illness. Some stories have uplifting endings, others more uncertain.

RESOLUTION (MHB-2002-35)

COMMENDING AND THANKING KQED FOR PRODUCING AND AIRING "HOPE ON THE STREET"

WHEREAS, the problem of the homeless mentally ill on our streets is one that has not been well understood by the public, leading to a general sense of hopelessness and frustration about the issue, and

WHEREAS, California has provided funding for assertive and innovative outreach and case management programs which are proving themselves to be more effective than any approach attempted in the past, and

WHEREAS, people suffering from mental illness say the stigma against mental illness is often worse than the illness itself, and whereas, this stigma prevents an estimated 80 percent of mentally ill individuals from seeking treatment, and

WHEREAS, KQED through its program BayWindow, has produced an engaging, revealing, and sensitive documentary called "Hope on the Street," and

WHEREAS, "Hope on the Street" provides the uplifting message that there is hope for the mentally ill, even those living on the street, and that many of them can lead stable, fulfilling lives when given access to quality care, and

WHEREAS, this program will be shown throughout the country, will be used for inservice trainings for mental health professionals, and for years to come will be shown directly to the homeless mentally ill, inspiring them to seek treatment and stay with it, so they can live productive and healthy lives, now, therefore

BE IT RESOLVED, that the San Francisco Mental Health Board commends KQED for its commitment to producing "Hope on the Streets," a program of the very best quality and of great social value, and be it

FURTHER RESOLVED, that the Mental Health Board expresses its sincere gratitude to everyone who participated in creating, producing, and promoting "Hope on the Street," including most especially:

Michael Isip, Producer
Elizabeth Pepin, Associate Producer
Robert O'Geen, Editor
Sevda Eris, Outreach Coordinator
Sue Ellen McCann, Executive Producer

(Passed unanimously.)

Mr. Stinson: We've been asked by the School District to table our discussion of our resolution on the Wellness Centers, so they can have some more time to study it. This is a sign that our resolutions do really matter to people. This request reflects the extent to which people outside this Board care what we say.

5.0 NEW BUSINESS

Mr. Stinson: Due to the excellent suggestion by Ms. Walker at the Executive Committee meeting, we will have this item on the agenda, so Board members can make suggestions for things to be put on the agenda.

Ms. Walker: I have wondered sometimes if I had an item to bring, where would I bring it. But having this item on the agenda completely satisfies what I was wanting.

Mr. Stinson: I'd like to put on the agenda: Prop N (Care not Cash) and AB 1421 (LPS Reform).

Mr. Douglas: It might be a good idea to get a speaker from the Welfare Department. I'm really worried about Proposition N and the effect it will have on our people. Maybe at our Retreat we could have a speaker about this. I'd hate to wait until January to talk about that. Somebody must be in charge of that.

Mr. Luebkeman: It might be premature to discuss it at December Retreat. I've heard a committee is just being formed for implementation.

With regard to AB 1421, I'd like to have a fact-based presentation. I'm not familiar with everything in that legislation.

Mr. Stinson: We have studied this as a Board in the past, but this is something I think we should do for the current board. We have articles that can give you the background.

6.0 PUBLIC COMMENT

Mr. Shipley: One of the things on my mind is that we just had our local elections. The City and County of San Francisco and the glorious voters of this town did not pass the housing initiative for the city, but they did for the state. And we had the passage of Proposition N, in which Gavin Newsom promised 1000 units of housing, but I don't know where those units are going to come from.

Probably they will master lease rooms in SRO's, which is not really a home. If they master lease, they will have to provide services. But we don't know where the services are gong to come from.

As a member of the board of a supportive housing program and as a client activist, I am concerned that with the passage of prop N we're going to have more homeless out on the streets than we have now. And the City does not provide for the people already out on the street. The City still doesn't have the funds and the services needed. It's really a societal problem. No matter how much municipalities and private organizations do it's not going to be enough. It takes a village to raise people up off the ground.

Ms. Ruffin: I want to invite new Board members to come meet with me if you like to help get oriented to our system.

There being no further business, the meeting was adjourned at 8:31 p.m.

SAN FRANCISCO MENTAL HEALTH BOARD

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RETREAT NOTES

Mental Health Board

Saturday, December 7, 2002
1380 Howard Street, Room 537
San Francisco, CA 94103
9:00 a.m. - 4:00 p.m.

BOARD MEMBERS PRESENT: Ted Stinson (Chair); Bridgett Brown; Augusta Del Zotto, Ph.D.; Bob Douglas; Carol Knight; Andrea Leung, L.C.S.W., A.C.S.W.; Joel A. Leubkeman; chance martin; Toye Moses, Ph.D., M.P.H.; Rose Chung for Supervisor Aaron Peskin; Dorothy Shaffer, R.N., N.P., M.S.N., Kate Walker; Idell Wilson; Sandy Yuen;

BOARD MEMBERS ON LEAVE: Dennis Yun, M.S.W.

BOARD MEMBERS ABSENT: none.

PRESENTERS:
Bob Cabaj (Pronounced Suh-bye)(Director of Community Behavioral Health Services)
Jo Ruffin (Director of Community Mental Health Services)

OTHERS PRESENT: Helynna Brooke (MHB Executive Director); Rich Snowdon (MHB Administrator)

1.0 WELCOME AND INTRODUCTIONS

The meeting was called to order at 9:25 by Ted Stinson, Chair.

I'd like to start by saying thank you to all of you. In one sense it seems like we have so little time together, in terms of our Board meetings. But at the same time, when you step back and think about the amount of time we ask you to contribute to the Board, it's not trivial. I think it's a testament to your dedication that you give so much of your time. Part of what we're going to do today is to think about how we will make the best use of our time next year.

We have two Board members who are departing from the Board. Rick Nizzardini who is in a Mental Health Professional Seat has just accepted a position at Continuum HIV Services as the Director of Adult Day Health. Continuum is funded in part by Community Mental Health Services and therefore Rick will no longer be eligible for the Board. But he will continue attending the Program and Services Committee.

Also Robyn Buckins has had to submit her resignation. She's the single mother of four children and she felt she could not keep up with her responsibilities. She was in a Family Member Seat.

Our three overall goals for today are:

1. To learn.
Bob Cabaj will be with us at 11 a.m. and will be able to talk with us about the current state of affairs and about the budget.

2. To plan for 2003
There are a number of Board members who are attending their first MHB Retreat. We can think of the goals we set during the retreat as the foundation for your house--the better the foundation, the better the house will turn out at the end of the year. We want to shape a lot of great ideas into a couple clear and precise ideas and strategies.

3. To get to know each other better.
My own belief about knowing the people you work with is that having a personal relationship with someone helps when you are dealing with something trying or difficult. He or she is my friend and perhaps we disagree, but because of that friendship I'm willing to go the extra mile.

Now I'd like to ask each of you to introduce yourself.

Ted Stinson
Family Member Seat
Appointed by Supervisor Jake McGoldrick.

Being on the Board has been a great learning experience.

Helynna Brooke
Executive Director

Joel Leubkeman
Family Member Seat
Appointed by Supervisor Leland Yee
I'm looking forward to learning more, and learning the questions to ask.

Kate Walker
Consumer Seat
Originally appointed by Supervisor Sue Bierman, now by Supervisor Tony Hall

I was looking for something to do, and a friend of mine suggested that I look into the Board. I had no idea about the Board, but I applied and was accepted. I do believe I am a soul who has opinions. And I think, why don't we do it this way. Does everybody listen to me? No, they don't. If I disagree with something on the Board, there is still so much one can do. You can find what you want to do. It is enormously valuable to me for a number of reasons to be associated with you people and the other people you lead me to. You make me feel very satisfied.

Dorothy Shaffer
Family Member
Appointed by the Board of Supervisors

I was recruited by Helynna. I was in a parent group. I started coming to Board meetings in January 2001, before I was appointed to Board. I'm a school nurse in the Oakland School District.

Sandy Yuen
Public Interest Seat
Appointed by Supervisor Aaron Peskin

Some years ago I had worked at Suicide Prevention. For a while after that I left the mental health arena. When this opportunity came up, I jumped for it. This is a passion for me. I enjoy working with you.

Bob Douglas
Consumer Seat
Appointed by the Board of Supervisors

I've always been interested in government and I see this Board as part of government.

Bridgett Brown
Consumer Seat
Appointed by Supervisor Matt Gonzalez

Carol Knight
Family Member
Appointed by the Board of Supervisors

Helynna recruited me, and kept pushing me to fill out the papers. I had never had any experience on any board, and I thank Helynna, because this has been a tremendous experience. I'm a caregiver working with all ages. Being on the Board gives me the chance to be an advocate for children and seniors. There is still see a lot of stigma against the mentally ill. I will graduate next year with my MSW.

Rose Chung
Legislative assistant to **Supervisor Aaron Peskin** who has the Board of Supervisors Seat

I certainly enjoy hearing about mental health services. I always remind Supervisor Peskin about the mental health budget. This is one of my major responsibilities. It has been such a pleasant experience here.

Augusta Del Zotto
Consumer Seat
Appointed by Supervisor Gerardo Sandoval

I was recruited by Helynna and Supervisor Sandoval. I've been an advocate for mental health as a way of creating social change for many years. As a consumer, I have PTSD. I'm very familiar with violence and what that creates and the possibility for healing.

Toye Moses
Mental Health Professional Seat
Appointed by Supervisor Tom Ammiano

I was initially appointed by the full Board and served two terms, and was off the Board for a year. Then Helynna dragged me back. Things have changed. I really, really like this Board, it's very dedicated. Just to see Aaron Peskin's aide coming to our meetings is great. Helynna has done a great job of getting everyone involved. I work for the City. I have a part time job working occasionally in the jails, at Jail Psychiatric Services.

chance martin
Public Interest Seat
Appointed by Supervisor Chris Daly

I have worn all the hats someone could wear on this Board. I grew up as Family Member of a person who had spent a long time in State Psychiatric hospital. I have been a provider. Then I became a consumer. Until you've walked from one side of the desk to the other, you don't know what it's like. I'm a Family Member again. I work for the Coalition on Homelessness, You have permitted me to be here, even though I helped shut down a meeting of the Health Commission meeting once.

I'm looking for avenues of change that are not so confrontational and in your face. In your face has a place, but so does the gentle persuasion part. I want to learn more about the gentle persuasion part.

Jo Ruffin
I'm the Mental Health Director, on my way to retirement. Yesterday was my seventh anniversary. This is the longest term of service for a Mental Health Director.

I have worked with the Board for all my career in Mental Health during the past 36 years. I've seen the Board grow and change and become one the most effective Boards I've ever seen. Not only in terms of what you do as individuals, but what you do as a whole. I can't tell you how much I appreciate working with you, and how much I appreciate the time you spend doing the very difficult tasks you do.

I really appreciate being here today. And I think Dr. Cabaj who's taking over will find a good resource in you and great advocacy.

Thank you for all those many years.

2.0 GETTING TO KNOW EACH OTHER

Mr. Douglas and Ms. Wilson led exercises to help Board members get to know each other better.

3.0 CMHS PRESENTATION WITH JO RUFFIN, DIRECTOR OF MENTAL HEALTH, AND BOB CABAJ, DIRECTOR OF BEHAVIORAL HEALTH.

Mr. Stinson: The City spends $130-150 million on mental health services during the year. This is a lot of responsibility that CMHS has and that we have as the community board for CMHS. It's important that we represent the community well and make solid recommendations.

Ms. Ruffin: I'd like to begin with a retrospective look at the City and mental health services, and then ask Dr. Cabaj to talk about the future.

I was thinking a little about how I got into administrative work. When I graduated in social work, I drove straight to California from Utah and got a job as social worker. I never planned to stay 36 years. But opportunities kept opening to me. I started out working in the San Bruno and downtown jails. This was before Jail Psychiatric Services was formed. There were just two of us in those days.

Later, I continued to work as a social worker in one of the outpatient clinics. There was a client who was very fearful, and he pulled a gun and shot the doctor I was working with. We were all in the room with that doctor. We ended up with a bit of PTSD. But in those days people didn't understand PTSD or what to do with it. We kept talking about it with each other, and one of the administrators said, "Well you guys are hysterical. We're going to split you up so you can calm down. I got sent to a geriatric day treatment program. I thought, "If I have to work some place I don't want to be, I might as well make more money. In those days, we just had a clinic that would do some home visits.

I didn't know much about older adult services. I discovered that in San Francisco we have about 20-22% seniors, about double the national average. We built a system of services for older adults. It was out of that experience that I developed the System of Care idea and the upside down triangle. And that was when I moved into administration. Even though I really liked direct, clinical care, I could affect more lives in administration.

Those concepts around the System of Care is what I still operate from.

Mental health services got "realigned" about ten years ago. That meant that the state mental health dollars started coming out of sales tax and the Vehicle Licensing Fund, and that meant we had a steady funding stream for a change. So we really want to guard those funds. The idea was that those revenue sources would grow and services would grow with them. But that hasn't happened. In the future people will be looking at realignment and see if it needs to be changed.

Realignment also gave the counties all of the money and let the county decide what services it would buy with those funds, including how many beds we wanted to buy at Napa State Hospital or in locked facilities. It was because of that change that we were able to create a bond issue in San Francisco to build the Mental Health Rehabilitation Facility, which is the only locked unit in San Francisco. The planning and design of the MHRF was one of the functions the MHB worked on. The Board was involved in the physical design and program development. The MHB also hosted a reception and art show at the MHRF just before it officially opened.

San Francisco General Hospital now manages the facility. So that part of our budget is actually in the SFGH budget.

The next big change was that we moved into managed care. The State created what was called a Medi-Cal "carve out" for mental health services. The State asked all of the counties to serve as the mental health component of managed care. If counties chose not to do it, the State would take charge and decide on services. We felt, and the Mental Health Board felt, that it was very important for us to have local control.

Thus, we consolidated all the private fee for service money into one program, along with the Medi-Cal funding, and this was called the San Francisco Mental Health Plan. The Mental Health Board held hearings about what that plan should look like, and held public meetings about the grievance process and how that would occur.

You are the Board of the San Francisco Mental Health Plan in addition to being the Board of the City's mental health system as a whole. We're trying to make the Plan as friendly as possible and open up access.

One thing that is special in San Francisco, and the Mental Health Board was very helpful in establishing this, is our Single Standard of Care. This means all the services that Medi-Cal people receive will also be given to people who are indigent, underinsured or uninsured. There was no state money for the Single Standard of Care. Advocates, including from the MHB, lobbied the Supervisors and the Mayor about why this was important. And we've been able to keep it funded ever since.

But this Single Standard is something to watch closely as the budget crisis develops.

San Francisco has a grant from the State for outreach to the homeless mentally ill (AB 2034). There is money for housing included in that grant. One of the times when I was gone on surgery, we got into trouble with the State Department of Mental Health. There was negative press around the whole thing in Matier and Ross. You arranged for the State Mental Director to come take a tour of the program, including going out on the streets with the outreach workers. Then he came to your Reception, and by the end of the day he was praising the program. Our credibility was in jeopardy and what the Board did was important for keeping the grant coming to San Francisco.

Another thing to watch is LPS reform. LPS stands for the Lanterman Petris Short Act. This is the legislation that defines the rules for involuntary patient care. A couple years ago there was a proposal by Helen Thomson, to create involuntary outpatient treatment. The original Thomson bill was much more dramatic than the final version. (AB 1421).

When the original bill came out, the Mental Health Board held a huge hearing in Koret Auditorium at the Main Library. All of that feedback went back to Sacramento. An agreement was made in Sacramento, that while there would be legislative support for additional involuntary treatment, it would not be done at the expense of the voluntary treatment programs already in existence. Now instead of instituting a massive change, AB 1421 gives the option to counties to provide a pilot program to see if assisted outpatient treatment is viable. This is a key point in trying to protect the services that do exist.

There is just simply not enough voluntary treatment. If we ever got to the point that we had enough voluntary treatment, then we would be much clearer about the need for involuntary outpatient treatment. It's important not to fight with each other over this. There will be more happening with regard to involuntary outpatient treatment because our society is very concerned about people who are perceived as a problem. This goes right to the heart of the stigma problem.

Another issue you had a tremendous effect on was the Police Crisis Intervention Training. You have taken part in the training itself. Helynna has worked hard to create the training and keep it going. The fact that you have allocated some of her time to the PCIT has made all the difference in the world. Our relationship with the Police Department is the best I've ever seen it. We now have the Police Liaison housed with us at 1380 Howard. I think that will help us significantly.

You have advocated for increasing the funding for the Mobile Crisis Treatment Team to 24/7, and this is something CMHS wants to do.

Mickey Shipley, from your Board, co-chaired the planning group for the 24/7 Drop-in Center.

We're currently doing an analysis of the cost of implementing AB 1421 and we'll deliver that report to you as soon as it's finished.

There is a little bit of money from the supervisors, just one time money. We want to get an RFP out for a component of the Drop-in Center to help advocate for it.

The big push for me, and last thing I want to mention, is our work on the Recovery Model. This model is extremely important. What it means is that we want to move beyond the concept of maintenance services. We want to think about what it means for a mental health client to recover. This is not about being on meds or not. What kind of life can I have, besides the fact that I have a mental illness?

It is possible to have a life. How can the services work with people toward that goal and not just focus on: "Are you on your medication or not?"

We've done a lot with Jail Psych services, and the Mental Health Board has been very helpful in bringing Jail Psych more to the forefront.

Now I want to introduce Dr. Cabaj . He has been the CMHS Medical Director for two years. Before that he was the Medical Director for 7 years in San Mateo County. Before that worked in Substance Abuse in San Francisco. He was the Medical Director of the consult team at SFGH.

We are very fortunate that he lives in San Francisco and knows our programs well. He's originally from Chicago and graduated from Harvard. Mitch Katz was Bob's medical student at Harvard.

Bob has written a couple books and a number of articles. He's an addiction specialist as well as being a psychiatrist. He's wonderfully skilled in both of those areas, and is now leading the system in creating a behavioral health model.

About 70% of our clients have substance abuse issues, and a fairly high percentage of substance abuse clients have mental health problems. If someone has schizophrenia, their chance of being hospitalized increases 10 times if they are using a substance. That's one of the reasons we have to do a better job of treating the whole person.

Bob goes everywhere on a bicycle. He can usually get to a meeting faster than people looking for parking.

Dr. Cabaj: I'm excited about this chance for you to get to know me and for me to get to know you.

About 95-98% of our clients who get rehospitalized within 30 days of leaving the hospital have substance involvement.

I grew up in Chicago. My dad was a bartender. His career advice to me was: whatever you do, don't sit around all day and listen to people complain. I just listen to people complain and give them pills instead of drinks. My mom worked for Coke.

I used to be a bus driver before I went to medical school. I also analyzed sewage. That was a another job. I went to Notre Dame. I grew up in the radical 60's and did a lot in civil rights. I was arrested in Chicago at the convention in 1968. In 1970, I went to Harvard for medical school. Very early on I got interested in addiction and in mental health.

I went to a program called the Cambridge Hospital Residency Program. It was one of the very first fully dedicated community psychiatry programs in the country. Much of what I still know and work with comes from that model. Then I worked at Mass General, and Beth Israel.

Then I started getting involved in minority health issues, especially regarding lesbian, gay, and transgender people. I was involved in the revision of the diagnostic manual (DSM) around cultural competency.

Studies of diagnosis and medication focus on white, middle class, young males, and this leaves out huge groups of people.

I'm still on that committee that deals with cultural competency. We are transforming it into the public psychiatry arm of the APA. I was also the Chair of the Committee on the Use and Abuse of Psychiatry, but gave it up. It was too much work given my schedule. I'm involved with the APA minority selection committee, encouraging minority students. I serve as a mentor for minority students.

I first visited San Francisco in 1971; knew I wanted to be here. I moved here in 91.

I created the Substance Abuse Consult Service at SFGH, and it's still there. I helped create one of first case management programs, which eventually became Citywide and Community Focus. Some of the staff I hired are still working there.

I'm currently on the Governing Board of the California Mental Health Directors Association. I'm the Chair of the Medical Services System of Care Committee.

I've been consulting with Larkin Street Services since 1991.

Some of the issues I see looming ahead of us in the coming year are:

Integration of mental health services and substance abuse services into Community Behavioral Health Services. We're developing a plan for the process of doing the integration. We'll present the plan to the Health Commission in March or later. It will be a three-year plan, with the target of implement Behavioral Health in 2005.

Our vision is "Any Door is the Right Door." I get so frustrated when I'm called about a client being turned away from treatment, because he had a drink three months ago. So what?

I want our attitude to be: If we are not the right place, we will help you get to the right place.

Patient Flow Project. The goal is that every client should be at the appropriate level of care. People are backed up in our system. There are people stuck on the inpatient wards, because there is no other place for them to go. There is a downside to this economically, but this is also a matter of client rights and civil rights. People get worse when they are not at the right level of care.

We've got the administrative day rate down by 2/3 and the length of stay is cut in half. There is concern about whether we are pushing people out too soon. The answer is no, because the re-admission rate has not gone up. We are not using private hospitals anymore. We have been able to develop openings in programs that were filled by helping to move people along.

Advance Access. If you ask a clinic how long it will take to see a client for the first time, it can be up to 8 weeks. Studies show that most clients who get rehospitalized, that happens within 30 days. So it's a no brainer that you need to see people right away when they are needing help.

We hope by February 1st, that people will be seen the day they need to be seen. Mission has done it quite successfully already.

All of this patient flow, getting people to the right level of care, ties in with the Recovery Model, which focuses on how much people can do for themselves. We clinicians can't be parents; we don't want to infantilize people.

Integrating substance abuse services and mental health services is key to creating the new behavioral health services. But we also want to be integrating physical health care. We're piloting a project of bringing the primary care nurse right to the clinic. Or having a good referral system. I'd like to build a clinic that has mental health and physical care in the same building.

The budget is a big issue. We are going to be facing cuts. We're told we have to absolutely give a 3% budget cut. The Department of Public Health has a billion budget. We are a rich city, but don't feel it. It feels like we are at bare bones. We have to look at how we can do cuts, particular programs, or agencies. We're beginning that process. Barbara Garcia is trying to look at this in an equitable way.

We'll have more detail in a month or two and we will want your input on that.

State has cut us, too. There are cuts to the Children's System of Care. EPSDT funding is now requiring a 10% match on any new EPSDT, which is not bad but it's still a cut. There is also a cut to our AB 2034 program.

We want to still try to serve the same number of people in our mental health services, which was 21,000 this past year. Substance abuse services has 14,000 clients.

We want to use evidence-based practices. We want to increase entitlements for our clients, to make sure everyone who should be on Medi-Call or SSI actually is on those programs.

OBOAT project: Office-based Opiate Addiction Treatment. We hope to get it rolled out in January or February. This means that methadone could be distributed through family clinics and private doctor's office. The federal government is holding us up right now.

We have 1,600 opiate addiction treatment slots, which are always full. There are 10-12,000 more addicts who say they would accept treatment if they could get it. We estimate that there are 18,000 addicts in San Francisco.

Harm reduction is a key theme in all our work, but the federal government has just said you cannot use harm reduction in grant applications for SAMHSA anymore.

I want to work closely with the regional centers regarding clients with developmental disabilities.

With regard to **Child Crisis**, we want to make other private insurers pay for services that are used by their members. Right now the City is bailing them out.

The establishment of the **Mental Health Court** was a bit of a curve ball. We were advocating for a Behavioral Health Court.

We're trying to get better placements for some of the **youth leaving YGC.** And have better responses to violence issues. CERT, the Critical Emergency Response Team, will be directly under the City.

Pharmacy Services. We have to have the money to pay for the medications that help people stay stable in the community.

With regard to **Prop N**, "Care not Cash", we're waiting to see what happens.

Residency training. The best way to get a psychiatrist to join your system is to have them train with you and get to know your system. We're currently working with UCSF and UC Davis. I'd like to develop our own residency. We have one of the richest systems in terms of opportunities for training. I'd like us to have a program of 16 residents. For that, I need about $1.2 million.

Mr. Douglas: I know some people who got methadone, and they had to go every day of the year to the clinic. Are you changing that?

Dr. Cabaj: The OBOAT project is hoping to have it at private doctor's offices and maybe at local pharmacies. Safeway, Walgreen, Rite Aid, almost agreed and then backed off. If they agreed, then clients could pick up their monthly supply, if they are doing well.

Dr. Moses: First I want to thank Jo for the wonderful job she has done. She has been working nonstop. We will miss you dearly for all you have done.

Now we're going to have our own doctor. My concern is, you are a medical person, you have great experience, are you going to have an assistant who will help you? Who is going to take care of all the work Jo was doing to make sure the consumers receive proper treatment, and the providers receive proper treatment?

Dr. Cabaj: I've given up one of my committees. I have a 1,000-page book on homosexuality and same sex marriage. They want me to do another book, but I'm holding off on that. Most of my focus will be here in San Francisco. I used to be President of the Northern California Psychiatric Society. I'm the past President of the Gay and Lesbian Medical Association. I'm retiring from both of those.

Jorge Partida is my Deputy Director for Behavioral Health and he is in charge of Substance Abuse Services. I just hired two new people to work as assistant directors to replace what Nancy Presson, Louise Rogers, and Wayne Clark did. We're combining three positions into two. We'll have good strong people, representative of our diversity. One of them will be my direct assistant.

Dr. Moses: What about advocating for people in Jail, since Jail Psychiatric Services is no longer under mental health?

Dr. Cabaj: I used to run services in the San Mateo County Jail. I have a close working relationship with Joe Goldenson and Jo Robinson, the directors of the jail programs here in San Francisco, and we will strongly advocate, because so many of our clients are ending up in jail.

Ms. Ruffin: Though the jail health programs are not in our division, we work closely with them. I meet regularly with Jo Robinson. We have their program director come to our CMHS program director meetings.

4. STRATEGIC PLANNING

Ms. Brooke and Mr. Snowdon led the strategic planning section of the day. Following are the issues which were discussed, along with possible action items for each, and the number of preliminary votes each one received.

These issues will be brought up at the January 8, 2003, Board meeting and comments will be taken from the public before the final vote is taken on which ones the board will focus on.

POSSIBLE ACTION ITEMS FOR 2003

These are urgent and challenging issues we'll be facing in 2003, but they are not required, so we can choose which items we want to focus on and what actions we want to take.

1. Budget cuts threatened (9 votes) FIRST PRIORITY

☐ Get monthly updates at MHB meetings during the Director's Report.
☐ Talk with the Health Commission about their strategy to defend health funding.
☐ Discuss and decide on our strategy for our annual Budget Resolution.
☐ Decide if we want to use the Annual Report strategically to argue for funding.
☐ Decide if we want to use our Annual Reception strategically to advocate for funding.
☐ Meet individually with all Supervisors to make our case.
☐ Testify at hearings before the Health Commission and the Board of Supervisors.
☐ Work with other organizations to help increase public support for health funding.
☐ In the case of budget cuts, work with CMHS on strategizing where the cuts will be made.
☐ Advocating at State and Federal level.
☐ Create a compelling story.
☐ Issue a press release, Meet with editorial boards.
☐ See if private pay system can make up some of the difference.
☐ Work on private/public funding, specifically pharmaceutical companies.

2. Integration into Behavioral Health Services (7 votes) THIRD PRIORITY

☐ Get periodic updates at MHB meetings during the Director's Report.
☐ MHB members participate in focus groups and on planning committees.
☐ Ask an MHB Committee to follow developments, reviewing the hopes and concerns different stakeholders have, and recommend to the Board any response that is needed.
☐ Ask for a presentation to the Board once the first major draft of the integration plan is written, when there is still plenty of time for input.
☐ Effective implementation of policies, so they are really carried out.
☐ Communicate with line staff.

3. Implementation of Proposition N, Care Not Cash (8 votes) SECOND PRIORITY
☐ Connect with other organizations which are monitoring Prop. N to find out about their positions and strategies.
☐ Ask an MHB Committee to get a report on the official implementation plans and recommend any needed response or action items.
☐ Find out if a Board member can be involved on any of the committees which are planning implementation.
☐ Monitor implementation.
☐ Wait and see what happens with court case.

4. Implementation of AB 1421 (2 votes)
☐ Ask an MHB Committee to get the report from CMHS (which is almost finished) on the implementation plans, costs, and strategies, and recommend any needed response or action items, especially looking for common ground, given that the MHB is divided on this issue.
☐ Continue to support mental health funding, and to support 24/7 Mobile Crisis and the 24/7 Drop-in Center which are two programs the Board has consensus on, and which can help prevent some of the need for involuntary commitment.
☐ Put on January or February meeting for discussion.
☐ Monitor formularies and protocol, if instituted.
☐ Find out what other counties are doing.
☐ Communicate with line staff.

5. 24/7 Mobile Crisis (6 votes) (Combined with 6)
☐ The MHB has already passed a resolution on 24/7 Mobile Crisis.
☐ Advocate for the budget to include the necessary funding for 24/7 Mobile Crisis.
☐ Ask a Supervisor to hold a hearing on 24/7 Mobile Crisis and 24/7 Drop-in to publicize the importance of these two strategic programs.
☐ Develop data that supports reduction of other costs of implementation.
☐ Educate the public about this service.
☐ Communicate with line staff.

6. 24/7 Drop-in Center (Combined with 5)
☐ Ask a Committee to have a presentation and develop a resolution on 24/7 Drop-in for the Board to pass.
☐ Advocate for the budget to include the funding necessary.
☐ Ask a Supervisor to hold a hearing on 24/7 Mobile Crisis and 24/7 Drop-in to publicize the importance of these two strategic programs.
☐ Data to show cost effectiveness
☐ Communicate with line staff

7. Wellness and Recovery (0 votes)
☐ Ask a Committee (along with Kate as liaison to the Wellness and Recovery Task Force) to develop a resolution on Wellness and Recovery for the Board to pass, regarding support for all the wrap-around services, such as housing and vocational

training, which make recovery possible, and regarding consumer participation in planning and policy and consumer employment in the system.
☐ Ask the Committee to study the proposal for a Wellness and Recovery Center to be run by consumers, and make a recommendation to the Board regarding it.
☐ Look at alternatives that will enhance wellness and recovery.

8. **Mental Health Court (4 votes)** (Combined with 9)
☐ A presentation will be made on January 8, 2003, at our MHB meeting.
☐ The Execs can ask a committee to get periodic reports on the impact of the court, and make recommendations for a response or action by the MHB, if that seems appropriate. (The Court is under the control of the judges, and they have not sought input so far, and we don't know how much they will take.)
☐ Find out if a Board member can join the committees doing the planning for the Court.
☐ Making the judges aware of us.
☐ Public hearing regarding the Court.
☐ Send a letter to the judges expressing our concerns.
☐ Monitor potential criminalization of the mentally ill

9. **The mentally ill in the jails** (Combined with 8)
☐ Ask a Committee to study the issue and update the Board, including getting updates on Jail Psych services, Jail Aftercare, and the Mentally-Ill Offenders intensive case management program at Citywide Case Management.
☐ Advocate for a comprehensive approach to keeping people out of jail, including advocating for the mental health budget, 24/7 Mobile Crisis, a 24/7 drop in center, the proper use of the Mental Health Court, etc.
☐ Monitor abuse of Kick Tank/Safety Cell
☐ Advocate against criminalization of the mentally ill.

10. **Children's Issues (3 votes)**
☐ The Public Education Committee has developed a resolution for the Board to pass in January or February.
☐ Advocate for expanding the Wellness Centers to additional schools, and for increasing the number of clinicians and consultants working with the schools.
☐ Advocate for SFUSD to allow CMHS to provide more teacher training on mental health issues.
☐ Support CMHS administrators in their efforts to improve the working relationship with between CMHS and SFUSD.
☐ Programs for caregivers.
☐ Follow up with Family Mosaic Project
☐ Public education about services.
☐ Look for more ways to collaborate and for resources to know about each other.